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DEVELOPMENTS IN AGING: 1990
VOLUME 1

A REPORT

OF THE

SPECIAL COMMITTEE ON AGING UNITED STATES SENATE

PURSUANT TO

S. RES. 66, SEC. 19, FEBRUARY 28, 1990

Resolution Authorizing a Study of the Problems of the Aged and Aging

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LETTER OF TRANSMITTAL

U.S. Senate,
Special Committee on Aging,
Washington, DC, February 28, 1991.

Hon. J. Danforth Quayle,
President, U.S. Senate,
Washington, DC.

Dear Mr. President: Under authority of Senate Resolution 66, Section 19(c), agreed to February 28, 1990, I am submitting to you the annual report of the Senate Special Committee on Aging, Developments in Aging: 1990, volume 1.

Senate Resolution 4, the Committee Systems Reorganization Amendments of 1977, authorizes the Special Committee on Aging "to conduct a continuing study of any and all matters pertaining to problems and opportunities of older people, including, but not limited to, problems and opportunities of maintaining health, of assuring adequate income, of finding employment, of engaging in productive and rewarding activity, of securing proper housing and, when necessary, of obtaining care and assistance." Senate Resolution 4 also requires that the results of these studies and recommendations be reported to the Senate annually.

This report describes actions taken during 1990 by the Congress, the administration, and the U.S. Senate Special Committee on Aging, which are significant to our Nation's older citizens. It also summarizes and analyzes the Federal policies and programs that are of the most continuing importance for older persons and their families.

On behalf of the members of the committee and its staff, I am pleased to transmit this report to you.

Sincerely,

David Pryor, *Chairman.*

SENATE RESOLUTION 66, SECTION 19(c), 101ST CONGRESS, 2D SESSION [1]

SEC. 19. (a) In carrying out the duties and functions imposed by section 104 of S. Res. 4, Ninety-fifth Congress, agreed to February 4, 1977, and in exercising the authority conferred on it by such section, the Special Committee on Aging is authorized from March 1, 1990 through February 28, 1991, in its discretion (1) to make expenditures from the contingent fund of the Senate, (2) to employ personnel, and (3) with the prior consent of the Government department or agency concerned and the Committee on Rules and Administration, to use on a reimbursable basis the services of personnel of any such department or agency.

(b) The expenses of the committee under this section shall not exceed $1,200,008, of which amount (1) not to exceed $33,000 may be expended for the procurement of the services of individual consultants, or organizations thereof (as authorized by section 202(i) of the Legislative Reorganization Act of 1946, as amended), and (2) not to exceed $800 may be expended for the training of the professional staff of such committee (under procedures specified by section 202(j) of such Act).

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[1] Agreed to February 28, 1989.

PREFACE

In terms of aging and health care policy, the second session of the 101st Congress sharply contrasted with those of the first session. In 1989, the most notable legislative development was the repeal of the catastrophic health care law. Beyond repealing the most significant change in the Medicare program since its enactment in 1965, the Congress "stripped out" many important aging policy provisions from the Omnibus Budget Reconciliation Act of 1989. By contrast, 1990 was a year in which the Congress was successful in passing and enacting an extraordinarily large number of legislative initiatives of interest to older Americans and their advocates.

At the beginning of 1990, most prognosticators predicted that the election year would be full of contentious partisan battles over a wide range of issues that would yield no significant budget agreement and few notable legislative achievements of importance to older Americans. While partisan disputes did arise, particularly over the budget, the second session of the 101st Congress surprised most political analysts by finding a way to achieve a historic and unprecedented 5-year $490 billion deficit reduction agreement in the Omnibus Budget Reconciliation Act of 1990 (OBRA 1990).

Reaching agreement on a budget that could be supported by a majority of Congress and signed into law by the President was not an easy task. It took months and required that the Congress stay in session closer to the November election than it had in years. However, one of the primary reasons why it took so long to reach agreement was that the majority of the Congress would not accept a proposal included in the President's and the congressional leadership's initial budget summit agreement that called for $60 billion in Medicare cuts over 5 years. Finally, after scaling back total Medicare cuts to $42 billion and decreasing beneficiary cuts from $30 billion to $10 billion, as well as moderating a number of other politically unacceptable tax increases and various domestic cuts, the Congress passed and the President signed the OBRA 1990 into Public Law 101-508.

Notably incorporated into the budget agreement were a host of initiatives that were high priorities of advocates for the elderly and the Special Committee on Aging. These included: (1) taking the Social Security trust fund out of the politics of the unified budget; (2) directing the Social Security Administration (SSA) to relink local telephone lines to SSA field offices, rather than be automatically routed to a toll-free number; (3) strengthening SSA's representative payee program by improving protections for beneficiaries who are too disabled to manage their finances; (4) providing Medicare beneficiaries better protections against Medigap marketing abuses; (5) assuring that the Medicaid program has access to discounted prescription drug prices; (6) phasing out the urban/rural

Medicare hospital reimbursement differential; (7) providing States the option to expand their Medicaid program additional home- and community-based services as an alternative to institutionalization; and (8) amending the nursing home reform amendments of 1987 to address the implementation concerns of patients and their families, advocates, providers, and States. Every one of these provisions can be linked to Aging Committee hearings and/or legislation sponsored or consponsored by Aging Committee Members.

In addition to the significant number of legislative achievements that were enacted as part of OBRA 1990, there were other important legislative accomplishments that were included in other bills that were signed into law. One, in particular, merits special mention—the passage of the Older Workers Benefit Protection Act (P.L. 101-433). This legislation effectively overturned a troublesome Supreme Court decision that older employees' benefits are not protected under the Age Discrimination in Employment Act.

In 1990, the Aging Committee's four Washington, D.C.-based hearings, 10 field hearings, sponsorship of numerous seminars and workshops, and release of several consumer information prints contributed to an impressive record of achievements. The Committee's Washington-based hearings focused on topics ranging from Medigap supplemental insurance market abuses to major service delivery problems at Social Security to the health care needs of America's black elderly. Outside the capital, Senators held field hearings ranging from long-term care needs to rural health care shortcomings to retirement planning challenges.

The Committee's work on prescription drug prices serves as a good example of how substantive Committee involvement can raise an issue; provide needed information to the elderly, advocates, policymakers, and the media; and contribute to the development and enactment of legislation that effectively addresses the issue. The information presented at hearings and in staff reports on rising prescription drug costs and on ways to address this problem significantly contributed to the Congress' understanding of this issue. By the end of 1989, the two majority staff reports, "Prescription Drug Prices: Are We Getting Our Money's Worth?" and "Skyrocketing Prescription Drug Prices: Turning a Bad Deal Into a Fair Deal," were being used as the basis for the development of legislation to be introduced in 1990. By the end of the second session of the 101st Congress, this legislation was incorporated into OBRA 1990 and will save the Medicaid program more than $3.4 billion over 4 years.

Outside of hearings, the Aging Committee continued its innovative use of nonhearing formats. The Committee conducted four seminars on widely varying issues, ranging from the Medicare appeals process to promising aging research possibilities. In addition, four very successful workshops focusing on recommendations for the 1991 reauthorization of the Older Americans Act were held. Finally, the Committee held working group meetings with representatives of various and diverse populations of ethnic elderly. These meetings were held in preparation for hearings that are scheduled to take place in the 102nd Congress.

As always, the Committee continued its commitment to publishing consumer information prints and staff reports. These helpful publications ranged from tax assistance for older Americans to advice for selecting Medigap and long-term care policies to providing information designed to help lawyers and lay persons navigate through the complex disability determination process to a special publication for children of aging parents regarding understanding Medicare.

The Aging Committee is proud of these achievements. We are well aware, however, of the many challenges that continue to confront us and the Nation as a whole.

The staggering problem of access to health care for the aged and non-aged alike has been thrust onto the legislative agenda during the past year. At least 32 million Americans under the age of 65 lack health insurance. One-third of the U.S. population with incomes below the poverty level do not even qualify for Medicaid. These statistics highlight gaps in protection for even the most needy Americans. Likewise, while nearly 98 percent of older Americans are enrolled in Medicare, the elderly remain unprotected against the often-castastrophic costs of long-term care and outpatient prescription drugs. Moreover, access to health care in inner city and rural America continues to be a particularly overwhelming and unmet challenge. Finally, beyond the tremendous health care challenges facing us, there remain many problems related to fraud and abuse, income security, social services, age discrimination, and housing.

Solving these and other daunting problems requires a major commitment on the part of the Federal Government, as well as renewed efforts by the private sector. It remains to be seen, however, if a Federal Government that faces significant budget constraints for the forseeable future and new OBRA 1990 budget enforcement rules will be up to this task.

Ironically, in the face of these budget challenges, it is likely that the 102nd Congress will see a return to the debate on the merits of varying Social Security and capital gains tax cutting proposals. Far from raising additional revenue needed to meet many of the social policy challenges that face this Nation, these two proposals are viewed by most analysts as long-term revenue losers. This fact, added to a slowing economy, makes it seem safe to predict that raising any additional revenue to fund a wide variety of domestic needs will be an even more difficult task than usual. Moreover, following repeal of the Medicare Catastrophic Coverage Act in 1989, many Members of Congress will be hesitant to support major and expensive aging and health policy reforms unless they feel certain such legislation is strongly supported by the constituents who will be footing the bill.

Juxtaposed against this intimidating environment will be the introduction of a wide variety of comprehensive and modest health care reform proposals, including the recommendations in the Pepper Commission report. The Majority Leader of the Senate has indicated his desire to make health care reform, including long-term care, an extremely high priority. Likewise, many health care policy leaders on the Republican side of the aisle have indicated a great interest in moving health care reform initiatives. While an agreement on any major health legislation is unlikely, it is encouraging that so many have openly acknowledged the large number of problems with our health care system and are committed to addressing them.

If history is any judge, Congress will continue to find ways to beat the impossible odds against it and will address, most likely on an incremental basis, some of the very important challenges that confront older Americans. The Aging Committee will continue to do its part to focus on creative, cost-effective policy options that address, among other issues: (1) health care quality, access, and financing shortcomings in both the private and public sectors; (2) prudent administration of public and private income security programs; (3) continued shortcomings in the Equal Employment Opportunity Commission's enforcement of the Age Discrimination in Employment Act; (4) necessary improvements to social services and transportation programs, including the Older Americans Act for its 1991 reauthorization; (5) consumer and medical fraud and waste schemes; and (6) unmet housing and shelter needs.

The record demonstrates that the Aging Committee had a productive year. The report that follows discusses developments of importance to older Americans in 1990. In line with changes implemented in previous years, the report surveys only Federal policies and programs and focuses primarily on the major policy issues facing Congress and the legislative activity on those issues that transpired in the second session of the 101st Congress.

Similar to last year, comprehensive demographic and statistical information is not included in this year's report. Updated data can be found in an Aging Committee information paper entitled "Aging America: Trends and Projections."

We are proud to acknowledge the dedicated work of the authors of this report, the staff of the Special Committee on Aging. This report is a synthesis of the extensive working knowledge these professionals bring to the Committee.

The graying of America presents us with significant challenges and opportunities. Providing for the health, income, and housing needs of this ever-growing older population are only a few of the challenges. We must also seek better ways to enable older Americans to remain productive and independent. Our greatest challenge then is to expand opportunities, to put to use the full talents of this vast resource so that the promise of long life is worth living.

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DEVELOPMENTS IN AGING: 1990—VOLUME 1

MARCH 22 (legislative day, FEBRUARY 6), 1991.—Ordered to be printed

Mr. PRYOR, from the Special Committee on Aging, submitted the following

REPORT

Chapter 1

SOCIAL SECURITY—OLD AGE, SURVIVORS, AND DISABILITY

OVERVIEW

In 1990, Social Security emerged unscathed from a massive budget deficit reduction effort which dominated American politics. Other Federal programs felt the axe of budget cuts while Social Security was spared. To many, this demonstrated the power of the Nation's elderly population, and the continued popular strength of the Social Security program.

Although President Bush was willing to consider new taxes in the budget deal, neither he nor other participants in budget negotiations were willing to touch Social Security. They carried out 1988 campaign commitments many had made to protect Social Security from budget cuts. On January 1, 1991, Social Security beneficiaries quietly received a full 5.4-percent increase to offset inflation.

1990 was significant not only because of what *didn't* happen to Social Security in the budget debate, but also because of the many positive changes that were enacted into the program. That year, legislation introduced by Senator John Heinz, Ranking Minority Member of the Special Committee on Aging, and others, was enacted that took Social Security completely out of the Federal budget. Legislation was also enacted that improved certain benefit features and restructured program operations to improve public service.

The 1990 debate over Social Security centered around its relationship to the Federal budget. An initiative by New York Senator Daniel Patrick Moynihan to cut payroll taxes received more public attention than did any other Social Security proposal in many years. The debate sparked by Senator Moynihan's proposal and Senator Heinz efforts to take Social Security off-budget raised public awareness that Social Security reserves were being used to pay for general government operations. This awareness, in turn, made Social Security a less-appealing target for budget cutters, who were concerned about the public reaction to further use of Social Security trust funds for deficit reduction. Ultimately, the budget agreement removed Social Security from calculations of the Federal budget deficit. This will continue to isolate the program from future efforts to reduce the deficit.

In addition to removing Social Security from the budget, a number of other changes in the actual program were enacted by Congress, marking 1990 as a landmark year in Social Security legislation. In 1989, a number of legislative proposals affecting Social Security were seriously considered in deliberations over the deficit reduction bill, known as budget reconciliation. Although the House of Representatives and the Senate Finance Committee approved significant programmatic and administrative Social Security reforms, the bulk of these proposals were "stripped" from the final package due to political pressures. Many of these valuable reforms were enacted in 1990 as part of the Omnibus Budget Reconciliation Act of 1990 (P.L. 101-508). These reforms included benefit liberalizations for certain categories of widows and widowers, reopening of telephone access to local Social Security offices, increased representative payee oversight, and various public service improvements.

The public attention raised by Senator Moynihan's tax cut proposal heightened the urgency of removing the trust funds from Gramm-Rudman-Hollings (GRH) calculations. Senator Moynihan commands respect and authority as a champion of the Social Security system. Senator Moynihan had played a key role in crafting the legislation in 1983 which had created growing reserves in the Social Security trust funds. When he proposed to cut the taxes to eliminate the annual surpluses, returning the Social Security system to a pay-as-you-go basis, it struck a receptive chord. Although Senator Moynihan was unable to forge a consensus around his proposal, he succeeded in building a considerable coalition in its support. The tax cut proposal promises to continue to be the most controversial and widely debated Social Security issue in 1991.

In 1990, as promises to be the case in 1991, the debate over Social Security was connected to concerns over the Nation's massive budget deficit. Although Social Security is a self-financing program that has not contributed to the deficit, it nevertheless plays an enormous role in determining how the Federal Government finances the deficit. Until 1991, under the Gramm-Rudman-Hollings law, Social Security trust funds were factored into the deficit totals used to determine the deficit reduction targets that the Congress was required to meet to avoid across-the-board cuts in Federal spending. Because of this accounting method, the deficit totals were reduced on paper by the amount of the Social Security reserves. In

1990 alone, the inclusion of Social Security reserves offset an estimated $63 billion in the general revenue deficit. Thus, the larger the Social Security trust funds grew, the smaller the deficit appeared.

Although this will no longer occur since Social Security has been taken out of deficit calculations, larger Social Security trust funds continue to allow the Federal Government to borrow less from the public. This arguably helps keep interest rates lower. Current law requires Social Security reserves to be invested in interest-paying Treasury securities. These assets are then used to finance other Federal programs. By borrowing from itself, the Government does not compete with those in the private sector seeking financing. As a result, the debate in 1991 over the Moynihan proposal will certainly focus on how the Federal Government can offset the tax revenue loss with new sources of revenue. Many supporters of Senator Moynihan's approach argue that a less-regressive form of taxation, such as income taxes, could be used to replace the revenue loss.

Congress created new rules in OBRA 1990, known as "fire wall" procedures in an effort to protect Social Security reserves. The Senate provision prohibits the consideration of a budget resolution calling for a reduction in Social Security surpluses and bars consideration of legislation causing the aggregate level of Social Security spending to be exceeded. The House provision creates a point of order to prohibit the consideration of legislation that would change the actuarial balance of the Social Security trust funds over a 5-year or 75-year period. These fire wall provisions will make it more difficult to enact changes in the payroll tax rates, as Moynihan has proposed, or in other aspects of the Social Security programs.

A host of problems in the administration of the Social Security programs attracted attention in 1990, and are likely to remain at issue in 1991. The staff at the Social Security Administration (SSA) has been cut by 21 percent, or 17,000 people, over the last 6 years, even though the number of beneficiaries was increasing. As an example of the problem, in order to centralize operations, SSA implemented a national 800-number. The system became a fiasco. It was plagued by alarmingly high busy-signal rates, unreliable and inaccurate information being given to callers, and lack of proper follow-up work on calls that were received. In 1990, Congress had to step in to require SSA to reopen telephone lines to local SSA offices. Unfortunately, the field offices remain ill-equipped to handle many new telephone calls since their staff had been slashed and many employees relocated to operate the national 800-number. Congress can be expected to carefully evaluate SSA's implementation of the new law. Many other problems at SSA were compounded because the agency was understaffed and underfunded. As 1991 begins, SSA is already finding that its budget for the new fiscal year may be inadequate, so the problems encountered in 1990 will continue to fester. In addition, SSA is faced with a major administrative burden in implementing the volume of legislative requirements imposed by OBRA 1990.

In 1990, legislative efforts to supervise Social Security Disability Insurance (SSDI) centered on beneficiaries' rights with respect to administrative law and legal representation. Congress enacted legislation to streamline the attorney fee process and ensure the availability of legal assistance, and to permanently extend the provision permitting continuation of disability benefits pending appeal, permitting SSDI beneficiaries to protect their benefits without interpretation by the legal process. Congress also focused upon problems that continued to plague the disability determination process.

A. SOCIAL SECURITY—OLD AGE AND SURVIVORS INSURANCE

1. Background

The Old Age and Survivors Insurance (OASI) and the Disability Insurance (DI) program, together named the OASDI program—is designed to replace a portion of the income an individual or a family loses when a worker in covered employment retires, dies, or becomes disabled. Commonly known as Social Security, monthly benefits are based on a worker's earnings. In November 1990, $20.5 billion in monthly benefits were paid to Social Security beneficiaries, with payments to retired workers averaging $602 and those to disabled workers averaging $587. Administrative expenses were $2.4 billion, or around 1 percent of the total benefits paid during that period.

The Social Security program touches the lives of nearly every American. In 1990, there were nearly 40 million Social Security beneficiaries. Retired workers numbered 25 million, accounting for 62 percent of all beneficiaries. Disabled workers and dependent family members numbered over 4 million, comprising about 10 percent of the total, while surviving family members of deceased workers totalled over 7 million or 18 percent of all beneficiaries. During the same period, about 130 million workers were in Social Security-covered employment, representing approximately 94 percent of the total American work force.

In 1990, Social Security contributions were paid on up to $51,300 of earnings, a wage cap that is annually indexed to keep pace with inflation. Workers and employees alike paid 7.65 percent of earnings in Social Security taxes (of which 1.45 percent represents contributions to the Hospital Insurance portion of Medicare). For the self-employed, the payroll tax is doubled, or 15.30 percent of earnings. In 1991, the tax rates will remain the same, although the wage cap will rise to $53,400.

Social Security is accumulating large reserves in its trust funds. As a result of increases in Social Security payroll taxes mandated by the Social Security Act Amendments of 1983, the influx of funds into Social Security is increasingly exceeding the outflow of benefit payments. In 1990, Social Security reserves totalled an estimated $226 billion, compared with $163 billion in 1989.

(A) HISTORY AND PURPOSE

Social Security emerged from the Great Depression as one of the most solid achievements of the New Deal. Created by the Social Security Act of 1935, the program continues to grow and become even more central to larger numbers of Americans. The sudden economic devastation of the 1930's awakened Americans to their vulnerability to sudden and uncontrollable economic forces with the power to generate massive unemployment, hunger, and widespread poverty. With a deep concern for future Americans, the Roosevelt administration promptly developed and implemented strategies to protect the citizenry from hardship. Social Security succeeded and endured because of this effort.

Although Social Security is uniquely American, the designers of the program drew heavily from a number of well established European social insurance programs. As early as the 1880's, Germany required workers and employers to contribute to a fund initially for disabled workers, and later for retired workers. In 1905, France also established an unemployment program based on a similar principle. In 1911, England followed by adopting both old age and unemployment insurance plans. Borrowing from these programs, the Roosevelt administration developed a social insurance program to protect workers and their dependents from the loss of income due to old age or death. Roosevelt followed the European model: government-sponsored, compulsory, and independently financed.

While Social Security is generally regarded as a program to benefit the elderly, the program was designed within a larger generational context. According to the program's founders, by meeting the financial concerns of the elderly, some of the needs of young and middle-aged would simultaneously be alleviated. Not only would younger persons be relieved of the financial burden of supporting their parents, but they also would gain a new measure of income security for themselves and their families in the event of their retirement or death.

In the more than half a century since the program's establishment, Social Security has expanded and changed substantially. Disability insurance was pioneered in the 1950's. Nevertheless, the underlying principle of the program—a mutually beneficial compact between younger and older generations—remains unaltered and accounts for the program's lasting popularity.

Social Security benefits are related to each worker's own average career earnings. Workers with higher career earnings receive greater benefits than do workers with low earnings. Each individual's own earnings record is maintained separately for use in computing future benefits. The earmarked payroll taxes paid to finance the system are often termed "contributions" to reflect their role in accumulating credit.

Social Security serves a number of essential social functions. First, Social Security protects workers from unpredictable expenses in support of their aged parents or relatives. By spreading these costs across the working population, they become smaller and more predictable.

Second, Social Security provides income insurance, providing workers and their families with a floor of protection against sudden loss of their earnings due to retirement, disability, or death. By design, Social Security only replaces a portion of the income needed to preserve the beneficiary's previous living standard and is intended to be supplemented through private insurance, pensions, savings, and other arrangements made voluntarily by the worker.

Third, Social Security provides the individual wage earner with a basic cash benefit upon retirement. Because Social Security is an earned right, based on contributions over the years on the retired or disabled worker's earnings, Social Security ensures a financial foundation while maintaining beneficiaries' self-respect.

Social Security provides a unique set of protections not available elsewhere. Some criticize Social Security for its mix of functions. Some argue that Social Security should be a welfare program, providing basic benefits to the poor and allowing middle and upper income workers to invest their earnings in private vehicles, such as IRAs. Such an approach would undermine the widespread political support that has developed for the broad-based functions of the program.

The Social Security program came of age in the 1980's. In this decade, the first generation of lifelong contributors retired and drew benefits. Also during this decade, payroll tax rates and the relative value of monthly benefits finally stabilized at the levels planned for the system. Large reserves accumulating in the trust funds leave Social Security on a solid footing as it continues through the 1990's.

2. FINANCING AND SOCIAL SECURITY'S RELATION TO THE BUDGET

(A) FINANCING IN THE 1970'S AND EARLY 1980'S

As recently as 1970, OASDI trust funds maintained reserves equal to a full year of benefit payments, an amount considered adequate to weather any fluctuations in the economy affecting the trust funds. When Congress passed the 1972 amendments to the Social Security Act, it was assumed that the economy would continue to follow the pattern prevalent in the 1960's—relatively high rates of growth and low levels of inflation. Under these conditions, Social Security revenues would have adequately financed benefit expenditures, and trust fund reserves would have remained sufficient to weather economic downturns.

The experience of the 1970's was considerably less favorable than forecast. The energy crisis, high levels of inflation, and slow wage growth increased expenditures in relation to income. The Social Security Amendments of 1972 had not only increased benefits by 20 percent across-the-board, but also indexed automatic benefit increases to the CPI. Inflation fueled large benefit increases, with no corresponding increase in payroll tax revenues due to comparatively lower real wage growth. Further, the recession of 1974–75 raised unemployment rates dramatically, lowering payroll tax income. Finally, a technical error in the initial benefit formula created by the 1972 legislation led to "over-indexing" benefits for certain new retirees, and thereby created an additional drain on trust fund reserves.

In 1977, recognizing the rapidly deteriorating financial status of the Social Security trust funds, Congress responded with new amendments to the Social Security Act. The Social Security Act of 1977 increased payroll taxes beginning in 1979, reallocated a portion of the Medicare (HI) payroll tax rate to OASI and DI, and resolved the technical problems in the method of computing the initial benefit amount. These changes were predicted to produce surpluses in the OASDI program beginning in 1980, with reserves accumulating to 7 months of benefit payments by 1987.

Again, however, the economy did not perform as well as predicted. The long-term deficit remained. The stagflation occurring after 1979 resulted in annual CPI increases exceeding 10 percent, a rate sufficient to double payouts from the program in just 7 years. Real wage changes had been negative or near zero since 1977, and in 1980, unemployment rates exceeded 7 percent. As a result, annual income to the OASDI program continued to be insufficient to cover expenditures. Trust fund balances declined from $36 billion in 1977, to $26 billion in 1980. Lower trust fund balances, combined with rapidly increasing expenditures, brought reserves down to less than 3 months' benefit payments by 1980.

The 96th Congress responded to this crisis by temporarily reallocating a portion of the DI tax rate to OASDI for 1980 and 1981. This measure was intended to postpone an immediate financing crisis in order to allow time for the 97th Congress to comprehensively address the impending insolvency of the OASDI trust funds. In 1981, a number of proposals were introduced to restore short- and long-term solvency to Social Security. However, the debate over the future of Social Security proved to be very heated and controversial. Enormous disagreements on policy precluded quick passage of comprehensive legislation. At the end of 1981, in an effort to break the impasse, the President appointed a 15-member, bipartisan, National Commission on Social Security Reform to search for a feasible solution to Social Security's financing problem. The Commission was given a year to develop a consensus approach to financing the system.

Meanwhile, the condition of the Social Security trust funds deteriorated. By the end of 1981, OASDI reserves had declined to $24.5 billion, an amount sufficient to pay benefits for only 1½ months. By November 1982, the OASI trust fund had exhausted its cashable reserves and in November and December was forced to borrow $17.5 billion from DI and HI trust fund reserves to finance benefit payments through July 1983.

The delay in the work of the National Commission deferred the legislative solution to Social Security's financing problems to the 98th Congress. Nonetheless, the Commission provided clear guidance to the new Congress on the exact dimensions of the various financing problems in Social Security, and on a viable package of solutions.

(B) THE SOCIAL SECURITY AMENDMENTS OF 1983

Once the National Commission on Social Security Reform reached agreement on its recommendations, Congress quickly enacted legislation to restore financial solvency to the OASDI trust funds. This comprehensive package eliminated a major deficit which had been expected to accure over 75 years.

The underlying principle of the Commission's bipartisan agreement and the 1983 amendments was to share the burden restoring solvency to Social Security equitably between workers, Social Security beneficiaries, and transfers from other Federal budget accounts. The Commission's recommendations split the near term costs roughly into thirds: 32 percent of the cost was to come from workers and employers, 38 percent was to come from beneficiaries, and 30 percent was to come from other budget accounts—including contributions from new Federal employees. The long-term proposals, however, shifted almost 80 percent of the costs to future beneficiaries.

The major changes in the OASDI Program resulting from the 1983 Social Security Amendments were in the areas of coverage, the tax treatment and annual adjustment of benefits, and payroll tax rates. Key provisions included:

Coverage—All Federal employees hired after January 1, 1984 were covered under Social Security, as were all current and future employees of private, nonprofit, tax-exempt organizations. State and local governments were prohibited from terminating coverage under Social Security.

Benefits—Cost-of-Living (COLA) increases were shifted to a calendar year basis, with the July 1983 COLA delayed to January 1984. A COLA fail-safe was set up so that whenever trust fund reserves do not equal a certain fraction of outgo for the upcoming year—15 percent until December 1988; 20 percent thereafter—the COLA will be calculated on the lesser of wage or price index increases.

Taxation—One-half of Social Security benefits received by taxpayers whose income exceeds certain limits—$25,000 for an individual and $32,000 for a couple—were made subject to income taxation, with the additional tax revenue being funneled back into the retirement trust fund.

Payroll Taxes—The previous schedule of payroll tax increases was accelerated, and self-employment tax rates were increased.

Retirement Age Increase—An increase in the retirement age from 65 to 67 was scheduled to be gradually phased in between the year 2000 to 2022.

(C) TRUST FUND PROJECTIONS

In future years, the Social Security trust fund income and outgo are tied to a variety of economic and demographic factors, including economic growth, inflation, unemployment, fertility, and mortality. To predict the future state of the OASI and DI trust funds, estimates are prepared using four different sets of assumptions. Alternative I is designated as the most optimistic, followed by intermediate assumption II–A and II–B, and finally the more pessimistic alternative III. The intermediate II–B assumption is the most commonly used scenario. Actual experience, however, could fall outside the bounds of any of these assumptions.

One indicator of the health of the Social Security trust funds is the contingency fund ratio, a number which represents the ability of the trust funds to pay benefits in the near future. The ratio is determined from the percentage of 1 year's payments which can be paid with the reserves available at the beginning of the year. Therefore, a contingency ratio of 50 percent represents 6 months of outgo.

Trust fund reserve ratios hit a low of 11 percent at the beginning of 1983, but increased to approximately 57 percent by 1989. Based on intermediate assumptions, the contingency fund ratio is projected to increase gradually to 77 percent by the beginning of 1990. Even under pessimistic assumptions, assets are projected to reach 73 percent by the beginning of the next decade.

(D) OASDI NEAR-TERM FINANCING

Social Security trust fund assets are expected to increase over the next 5 years. Indeed, according to the 1990 OASDI Trustees Report, OASDI assets will be sufficient to meet the required benefit payments throughout and far beyond the upcoming 5-year period. Under all but the most pessimistic assumptions, both the OASI and SSDI programs will remain solvent on their own for many years. However, should conditions deteriorate drastically during the comming 10 years, SSDI trust fund assets could decline to dangerously low levels.

The projected expansion in the OASDI reserves is partly a result of recent payroll tax increases—from 7.51 percent (with an upper limit of $48,000) in 1989 tc 7.65 percent in 1990. The OASDI reserves are expected to steadily build for the next 20 to 25 years as a result both of the 1990 tax increase and an anticipated leveling off in the growth rate of new retirees.

(E) OASDI LONG-TERM FINANCING

In the long run, the Social Security trust funds will experience three decades of rapid growth, followed by continuing annual deficits thereafter. Under the intermediate assumptions, over the next 75 years as a whole, the cost of the program is expected to exceed its income by 5.4 percent. However, the expected surplus revenue of the system over the next 20 or 30 years provides ample time to monitor the program and take actions to ensure its solvency.

It should be emphasized that the OASDI trust fund experience in each of the three 25-year periods between 1989 and 2063 varies considerably. In the first 25-year period—1989 to 2013—reserves are expected to exceed costs by 2.14 percent of taxable payroll. As a result of these surpluses, contingency fund ratios are expected to build to approximately 312 percent by the year 2000.

In the second 25-year period—2014 to 2038—the financial condition of OASDI is expected to continue improving in the early years, but begin deteriorating toward the end of the period. Trust fund reserves are expected to grow to approximately 546 percent of annual expenditures by 2015, and then decline to 239 percent of outgo by 2035. Positive actuarial balances are expected through the year 2015, with negative balances occurring thereafter. Negative deficits are projected to peak around the year 2035, at 3.47 percent of taxable payroll. This combination of surpluses and deficits will result in an average deficit of 1.88 percent of taxable payroll over this 25-year period.

The third 25-year period—2039 to 2063—is expected to be one of continuous deficits. Program costs will continue to grow until 2035 and remain above annual revenues. By the end of this period, continuing deficits are expected to have depleted the trust funds. Under intermediate assumptions, exhaustion of reserves is projected to occur by 2046. If considered separately, depletion of DI reserves is expected by 2025, while OASI trust fund exhaustion is projected for the year 2049. Annual OASDI deficits over the 25-year period are expected to average 3.72 percent of taxable payroll.

(1) Midterm Reserves

In the years between 1990 and 2015, it is projected that Social Security will receive far more in income than it must distribute in benefits. Under current law, these reserves will be invested in interest-bearing Federal securities, and will be redeemable by Social Security in the years in which benefit expenditures exceed payroll tax revenues—2015 through 2063. During the years in which the assets are accumulating, these reserves will far exceed the amount needed to buffer the OASDI funds from unfavorable economic conditions. As a matter of policy, there is considerable controversy over the purpose and extent of these reserve funds, and the political and economic implications they entail.

During the period in which Social Security trust fund reserves are accumulating, the surplus funds can be used to finance other Government expenditures. During the period of OASDI shortfalls, the Federal securities previously invested will be redeemed, causing income taxes to buttress Social Security. In essence, the assets Social Security accrues represent internally held Federal debt, which is equivalent to an exchange of tax revenues over time.

Though the net effect on revenues of this exchange is the same as if Social Security taxes were lowered and income taxes raised in the 1990's and Social Security taxes raised and income taxes lowered in 2020, the two tax methods have vastly different distributional consequences. The significance lies with the fact that there is incentive to spend reserve revenues in the 1990's and cut back on underfunded benefits after 2020. The growing trust funds reserve enable the Congress to spend more money elsewhere without raising taxes or borrowing from private markets. At some point, however, either general revenues will have to be increased or spending will have to be drastically cut when the debt to Social Security has to be repaid.

(2) Long-term Deficits

The long-run financial strain on Social Security is expected to result from the problems of financing the needs of an expanding older population on an eroding tax base. The expanding population of older persons is due to longer age spans, earlier retirements, and the unusually high birth rates after World War II, producing the so-called baby-boom generation who will retire beginning in 30 years. The eroding tax base in future years is forecast as a result of falling fertility rates.

This relative increase in the number of beneficiaries will pose a problem if the Social Security tax base is allowed to erode. If current trends continue and nontaxable fringe benefits grow, less and less compensation will be subject to the Social Security payroll tax. In 1950, fringe benefits accounted for only 5 percent of total compensation, and Social Security taxes were levied on 95 percent of compensation. By 1980, fringe benefits had grown to account for 16 percent of compensation. Continuation in this rate of growth in fringe benefits, as projected by the Social Security actuaries, might eventually exempt over one-third of payroll from Social Security taxes. This would be a substantial erosion of the Social Security tax base and might undermine the long-term solvency of the system.

While the absolute cost of funding Social Security is expected to increase substantially over the next 75 years, the cost of the system relative to the economy as a whole will not necessarily rise greatly over 1970's levels. Currently, Social Security benefits cost approximately 4.5 percent of the GNP. Under intermediate assumptions—with 1.3 percent real wage growth—Social Security is expected to rise to 6.8 percent of the GNP by 2035, declining to 6.7 percent by 2060.

Although there is no question that reserves in the Social Security trust funds will build up well beyond the turn of the century, it nevertheless must be remembered that Social Security remains vulnerable to general economic conditions and should those conditions deteriorate, Congress may need to revisit the financing of the system. Furthermore, Social Security is not immune from political pressures to change its structure, notwithstanding its financial condition. Indeed, political and economic pressures in coming years to use the trust funds to reduce the Federal budget deficit may overshadow the attention paid to maintaining Social Security's solvency.

(F) SOCIAL SECURITY'S RELATION TO THE BUDGET

Over the last decade, Social Security has repeatedly been entangled in debates over the Federal budget. While the inclusion of Social Security trust fund shortages in the late 1970's initially had the effect of inflating the apparent size of the deficit in general revenues, the reserve that has accumulated in recent years has served to mask its true magnitude. In fact, many Members of Congress contend that the inclusion of the surpluses has disguised the enormity of the Nation's fiscal problems and delayed true deficit reduction. For these same reasons, there has been increasing concern over the temptation to cut Social Security benefits to further reduce the apparent size of the budget deficit.

In 1989, legislation was introduced in the Senate to halt the use of the Social Security trust funds to mask the true size of the deficit. Senators Heinz, Moynihan, and Hollings introduced legislation to remove the trust funds from the deficit reduction calculations. In late 1989, Senate Majority Leader George Mitchell and Speaker of the House Thomas Foley issued statements at a joint appearance committing themselves to working for legislative removal of the trust funds from the Gramm-Rudman targets. During consideration of a bill to extend the public debt limit to $3.12 trillion, Senator Heinz proposed to offer an amendment to remove the trust funds from the "deficit counting game." Due to time constraints, and because the Majority Leader and other Senators promised to fully debate the issue early in the next session, the amendment was not offered at that time.

On October 18, 1990, Senators Heinz, Hollings, and Moynihan successfully offered and passed an amendment to the 1990 Omnibus Budget Reconciliation Act to remove the Social Security trust funds from the GRH deficit reduction calculations by a vote of 98–2.

Senator Heinz also offered an amendment in the Finance Committee reconciliation mark-up urging the Budget Committee to exclude the Social Security trust funds from the deficit reduction calculations. This amendment was introduced and passed as part of the Finance Committee's closed-door executive session. With all Finance Committee members present, no opposition was voiced.

Prior to the passage of the Heinz-Hollings-Moynihan amendment, Senator Heinz was also successful on June 19, 1990, when he introduced an amendment to S. 566, the Housing Act of 1990. The Heinz amendment, which passed by a vote of 96–2, stated that it would be out of order for the Senate to consider any increase in the public debt limit until the Social Security trust funds were removed from the GRH deficit reduction calculations.

Many noted economists advocated the removal of the trust funds from deficit calculations. They say that the current use of the trust funds contributes to the country's growing debt, and that the Nation is missing tremendous opportunities for economic growth. A January 1989 General Accounting Office report states that if the Federal deficit was reduced to zero, and the reserves were no longer used to offset the deficit, there would be an increase in national savings, improved productivity, and international competitiveness. The National Economic Commission, which released its report in March 1989, disagreed among its members over how to tame the budget deficit. Yet, they unanimously agreed to the recommendation that the Social Security trust funds should be removed from the deficit reduction process.

Taking Social Security off-budget was partially accomplished by the 1983 Social Security amendments and, later, by the 1985 Gramm-Rudman-Hollings Act. The 1983 amendments required that Social Security be removed from the budget process by fiscal year 1993, and the subsequent Gramm-Rudman-Hollings law accelerated this removal to fiscal year 1986. To further protect the Social Security trust funds, Social Security was excluded from any budget documents, budget resolutions, and reconciliation, and barred from any G–R–H across-the-board cut or sequester. Inclusion of Social Security changes as part of a budget resolution or reconciliation bill is subject to a point of order which may be waived by either body. However, administrative funds for SSA remained subject to a budget sequester.

(G) NEW RULES GOVERNING SOCIAL SECURITY AND THE BUDGET

Congress created new rules in 1990, as part of OBRA 1990, known as "fire wall" procedures designed to make it difficult to diminish Social Security reserves. The Senate provision prohibits the consideration of a budget resolution calling for a reduction in Social Security surpluses and bars consideration of legislation causing the aggregate level of Social Security spending to be exceeded. The House provision creates a point of order to prohibit the consideration of legislation that would change the actuarial balance of the Social Security trust funds over a 5-year or 75-year period. These fire wall provisions will make it more difficult to enact changes in the payroll tax rates, as Moynihan has proposed, or in other aspects of the Social Security programs such as benefit changes.

3. ADMINISTRATIVE ISSUES AND CONGRESSIONAL RESPONSE

Over time, Congress has monitored the performance of the SSA in carrying out its most basic mission—high-quality service to the public. In the 1950's and 1960's, SSA was viewed as a flagship agency, marked by high employee morale and excellence in management and services. In the past 15 years, however, many have contended that the agency has lost its edge, and the quality of service has declined. Factors cited as causing this decline include new agency responsibilities, including the creation of SSI in 1972, staff reductions in the 1980's, inadequate administrative budgets, multiple reorganization efforts, and the fact that SSA has had high turnover in the Commissioner's office in the last 15 years. Many claim that the agency has sacrificed the quality of service to the public in an effort to cut costs through technology, and that public confidence in the agency consequently has declined. Despite a major investment by Congress, SSA remains troubled by computer, telephone, and other technological problems.

These criticisms have led Congress to intensify oversight of SSA, including numerous congressional hearings and requests for General Accounting Office investigations of SSA problems. One outcome has been an ongoing review of the agency by the GAO. During the past several years, GAO has released a series of reports on SSA staff reductions and their effect on the quality of service provided to the public, payment accuracy to beneficiaries, problems with the agency's creation of a national 800-number system, and fragmented leadership. Legislative proposals progressed from these concerns in 1990, including creation of an independent SSA and performance of specific service improvements.

(A) STAFF REDUCTIONS

Efforts to reduce the size of SSA's staff over recent years have continued to raise concerns about a deterioration in the agency's quality of public service. In 1990, SSA personnel totalled 63,000, down 17,000 from the staffing level of 1985. Officials at the Office of Management and Budget reportedly were proposing an additional reduction of 5,000 in SSA staff as part of President Bush's 1990 budget, despite growing and documented evidence of service problems resulting from previous staff cuts. Commissioner King, who had vowed to "fight like a junkyard dog" against such proposals, prevailed against OMB. Reportedly, President Bush himself reversed OMB's proposal, thereby preventing further staff cuts. The Chairman and Ranking Minority member of the Committee on Aging led a group of Senators in writing to the President applauding his decision. In view of continued congressional attention on the damaging consequences of cutbacks in staff, further proposals for staff cuts will be met with concern in the White House and on Capitol Hill. Under the leadership of Commissioner King, further staff cuts are not likely to be proposed. Yet the damage from previous staff cuts continues to hurt public service.

The philosophy guiding the SSA cuts was embodied in the 1983 Grace Commission Report. The Report recommended that SSA eliminate 17,000 staff positions and close over 800 field offices, based upon the rationale that operating a single large office in a city of 500,000 to 1 million would be cheaper than operating several small offices. Critics pointed out however, that the Grace Commission's rationale rested entirely on cost factors, and failed to assess the effect of closings on the quality of public service.

In 1984, SSA was asked to provide OMB with an estimate of the staff-year savings which could result from an agency computer modernization plan. The agency was fraught with disagreement regarding staff-reduction potentials and key persons were not involved in formulating the recommendation which eventually went forward. According to GAO, "it appears that SSA's inability to reach agreement and respond to requests * * * for staff-year savings and the resulting estimate * * * contributed to SSA's being in an essentially reactive position to OMB's call for a 17,000 staff reduction."

While most critics recognized that SSA needed to monitor its operating costs closely and that some staff reductions and office closings may have been necessary, they nonetheless believe that SSA has been pursuing cost cuts without regard to the quality of service being provided. Congressional testimony and GAO reports continued to reveal in 1990 that severe stress from increasing workloads is contributing to a deterioration of overall staff effectiveness. Critics cited the consequential loss of confidence in the system among younger workers, a declining number of whom plan to make a career of Social Security. Moreover, many older workers state that their only reason for remaining with the agency is to keep their Civil Service retirement benefits. The combination of many employees fast approaching retirement age, along with the SSA's increasing difficulty in retaining a pool of younger, lower level employees, threatens the future effectiveness of the agency.

Dr. Arthur Flemming, former Secretary of the Department of Health, Education, and Welfare, has expressed concern that this problem could have severe repercussions, especially given the rapid aging of the American work force. According to Dr. Flemming, morale problems within SSA are so severe that we stand to witness a deterioration in the caliber of SSA personnel at just the time when the burdens become heavier. Commissioner King acted upon these concerns, and has worked to stop a trend toward the dissipation of staff and the deterioration of services at SSA.

(B) NATIONWIDE TOLL-FREE NUMBER

On October 1, 1988, SSA launched a toll-free telephone system throughout 60 percent of the Nation that bypassed the agency's network of local Social Security field offices. From that point all calls to local Social Security offices were re-routed to a small number of teleservice centers. Despite a number of serious problems with the system and persistent congressional criticism, a year later the toll-free line went into effect throughout the entire country.

During 1990, the first year of nationwide operation, callers to SSA's toll-free line frequently were unable to get through or to obtain accurate information when they did. A hearing of the Special Aging Committee in May 1990 explored evidence that longstanding problems have grown worse. A GAO study commissioned by the Committee found that 43 percent of callers who were evaluated got wrong answers. One in five got wrong answers that could affect their benefit amounts. In addition, it was revealed that busy signal rates above 50 percent were commonplace. A hearing of the Senate Special Committee on Aging in April 1989 revealed that nearly one in four callers was given the wrong answer to questions about Supplemental Security Income.

With respect to the high busy signal rate, a GAO study conducted before the implementation of the toll-free system at the request of Senator David Pryor outlined a number of special steps SSA claimed that it was going to take to avoid this problem. Among them, the agency stated that it would carefully limit the promotion of the new toll-free line and work closely with aging advocacy groups to ensure that they did not over-sell the number. Many of these steps were not taken.

Amid growing congressional criticism of the toll-free system, SSA began detailing staff out of Social Security field offices and into the teleservice centers to help answer calls. According to GAO, some of these staff were unqualified to do so, while the accompanying drain on field staff jeopardized the ability of those offices to serve the public. GAO also concluded that studies SSA presented at the Aging Committee hearing indicating very low error rates were not methodologically sound and were, therefore, inconclusive.

From the start, SSA aggressively promoted the new service throughout the Nation as giving "the public one more option—for many, the most convenient option—of doing business with SSA". Critics of the new system, however, contended that this was misleading because under the new system the public lost the ability to contact their local Social Security field office.

In theory, many calls to the 800-number which require action by a field office are referred to the field office staff for a follow-up call. In practice, a GAO study for Congressman Andrew Jacobs, Jr., released in July 1990, found that about one in four callers surveyed never received a follow-up contact from a field office. This study drew sharp criticism of SSA by a number of Members of Congress and revealed the failure of the system to function as promised.

When callers of the toll-free line realized that they could no longer speak with staff in their local SSA office, many became upset and reluctant to discuss their financial affairs with a stranger. Moreover, callers cannot reach the same person twice over the toll-free line when a problem arises that requires more than one call to settle.

There is also a concern that callers may be given wrong information as a result of their call being handled out of State. For example, individuals with questions about their State's SSI supplementation rate may be given the rate for the State in which their call is taken rather than made.

Given the overwhelming evidence of the 800-number system's problems and widespread public dissatisfaction which was communicated to Members of Congress, a bill by Senator Pryor and Congressman Sander Levin to require SSA to restore access to local offices was enacted in 1990. The bill was strongly opposed by the Bush administration and SSA. Despite these objections, Congress had become frustrated with the system's repeated failures, SSA's unwillingness to reform and decentralize the system administratively, and the continued drain the system created on other agency resources, including staff. After numerous hearings, GAO reports and Committee investigations, Congress took the extraordinary step of enacting legislation governing SSA's telephone system, because of the perception on Capitol Hill of SSA's unwillingness to address concerns that had been repeatedly expressed.

Congress also enacted as part of the OBRA 1990, a provision to improve the 800-number system by requiring SSA to conduct demonstration projects in no fewer than three teleservice centers. As part of the project, individuals who call SSA will be provided with a written receipt which includes the date of the communication, a description of the nature of the communication, and any action SSA will take or any advice provided. The projects will continue for 1 to 3 years. The objective of the projects is to make SSA accountable for information and advice offered over the 800-number, and to provide callers with a receipt of contact to clarify for them what can be expected as a result of the call.

In defense of the new toll-free line, SSA contended that the overwhelming number of calls was evidence of its popularity and the public's implicit approval of the teleservice system. In response, critics pointed to the agency's aggressive promotion of the service and the fact that those in need of assistance from SSA have no choice but to call the toll-free line.

A more long-term concern examined at the Senate Aging Committee hearing was SSA's plan to make the toll-free line the "predominate mode" of service in coming years. Known as *Project 2000*, SSA's plan also would employ voice-activated answering systems in place of human beings.

Aging Committee Chairman David Pryor and a number of representatives of aging advocacy organizations expressed strong opposition to the depersonalized vision outlined in *Project 2000*. They emphasized that this approach was incompatible with SSA's mission to serve those who are highly vulnerable, who often need the one-on-one service to be fully responsive, and who frequently are intimidated by modern technology.

The new SSA Commissioner, Gwendolyn King, has distanced the agency from *Project 2000*. Despite concerted efforts to improve the toll-free line, however, problems of poor accessibility and inaccuracies continued and worsened in 1990. In the first week of January 1990, for example, three out of every four callers were unable to get through on the toll-free line. Although a traditionally busy time for the agency, similar episodes occurred in the preceding and following months.

Continued intense congressional oversight and concern over SSA's telephone system can be expected. Early signs of problems in implementing the legislation requiring local telephone access are creating concerns on Capitol Hill about SSA's commitment to carrying out the new law. The legislation included a provision requiring GAO to carefully study SSA's implementation efforts, and Congress can be expected to examine GAO's findings closely.

(C) REPRESENTATIVE PAYEES

In 1990, Congress enacted the most sweeping reform of SSA's system of appointing and overseeing representative payees in Social Security history. Representative payees handle the benefits of beneficiaries determined by SSA to be unable to handle their own finances. The Senate Aging Committee and the House Ways and Means Committee held hearings on the issue in 1989. That year, Chairman Pryor introduced a bill, S. 1130, which also proposed a comprehensive reform of SSA's representative payee system, which was approved by the Finance Committee. The House approved a similar significant package of representative payee reforms that year. Those bills were combined in a compromise package which adopted the strongest and best aspect of each approach. It was approved by Congress as part of OBRA 1990.

The final agreement corresponded closely with the provisions of S. 1130. The new law strengthens the requirement for SSA to investigate payees and to monitor their performance, with special attention to high-risk categories of payees. New recordkeeping is required to assess whether individuals are serving as payee for multiple beneficiaries and whether individuals appointed as payees had previously been suspended for inadequate performance or convicted of Social Security fraud. Creditors are barred in most cases from serving as payees, and provisions were included to help beneficiaries find suitable noncreditors to serve as payees. SSA is prevented from suspending benefits from most beneficiaries who are unable to find a payee for more than 30 days, and SSA is liable to repay stolen benefits if its staff had not properly followed guidelines designed to prevent misuse of funds. Certain organizations are allowed to charge a small fee to serve as payee for individuals without a family member or close associate to fill that role.

Both the House and the Senate moved in the same direction motivated by the same concerns for vulnerable beneficiaries and the perceived deficiencies in SSA's conduct of the program. SSA testified that it was taking administrative steps to improve payee oversight, and even moved independently to initiate some of the reforms proposed in Congress. This legislative package will require a significant commitment of resources by SSA to be properly carried out. Congressional committees involved in drafting and promoting the new law will closely oversee its implementation.

(D) SERVICE IMPROVEMENTS

Problems over the past years at SSA have resulted in a significant increase in complaints received by Congress on the quality of service provided to the public by SSA. Constituent dissatisfaction has been voiced with respect to the ability to get questions answered quickly and correctly; the ability to re-contact the same staff person who responded to an individual previously; the ability to file an application easily and quickly, and to have SSA promptly process changes in eligibility status without loss of benefits; and the ability to gain direct access to field office experts.

To remedy service problems, Congress enacted as part of OBRA 1989, significant portions of companion bills introduced by Senator Donald W. Riegle and Representative Sander Levin to improve SSA services. The remainder of the bills were largely enacted as part of OBRA 1990. The 1990 changes require SSA to: (1) Use clear and simple language in all of its notices to the public. In notices generated by local SSA offices, the telephone number of the office must be included. In notices generated by central SSA offices, the notices must include the address of the local office which serves the recipient and a telephone number to contact. (2) When a claimant who is denied benefits re-applies, rather than appealing, based on inaccurate or misleading information from SSA, the failure to appeal will not constitute a basis for denial of the second application. SSA will be required to include in all notices of denial a clear, simple description of the effect on possible entitlement to benefits of re-applying rather than appealing.

The changes that were enacted in 1989 require SSA to: (1) improve notices to the blind and study the need for additional notice improvements; (2) ensure that timely interviews are provided to visitors to local SSA offices who have time-sensitive problems; (3) provide recourse to claimants and beneficiaries who lose benefits because of inaccurate or incomplete information provided by SSA; (4) provide additional time to correct errors in individual earning records; and (5) consider a person's limitations (physical, mental, educational, and language) in determining whether a person acted in good faith or was at fault in taking certain actions in dealing with SSA.

The major remaining service improvement which will be a focus of attention in 1991 requires SSA to find more reasonable ways to collect overpayments without causing financial hardship. SSA is being urged to make this improvement on an administrative basis without waiting for additional legislation.

(E) SSA AS AN INDEPENDENT AGENCY

In 1990, the concept of making SSA an independent agency essentially stalled after having proceeded further than ever before in 1989. In 1989, differing proposals to accomplish the same end were approved by the House and the Senate Finance Committee and headed toward rapid enactment. As with many other proposals, it was not included in the final version of the reconciliation bill. Despite this progress, large differences remained between the House and Senate versions, and the administration remained intensely opposed to the idea, with top officials threatening to recommend that the President veto any proposal to make SSA independent. As a result of this lack of consensus, the proposal made little progress in 1990 and may continue to encounter severe resistance, particularly from the administration.

The creation of the unified Federal budget sparked proposals for Social Security cutbacks by the Nixon, Ford, and Carter administrations. These propositions served as an incubator for a movement to create an independent Social Security agency. Calls for agency independence increased when, during the early 1980's, Social Security funds were repeatedly mentioned as a means toward balancing the Federal budget.

During the past two decades, many have argued that SSA's administrative performance would be improved if it were established as a separate agency, independent of the Department of Health and Human Services (HHS). In its March 1981 recommendations, the National Commission on Social Security endorsed the establishment of an independent agency, as did a majority of the members of the 1983 National Commission on Social Security Reform. Many have recommended that a bipartisan board manage and oversee Social Security, as was the case in the first decade of the program—1935-46. Advocates of an independent agency often cite the need for continuous, consistent leadership in Social Security, which is needed to improve long-term management and effectiveness of the agency, and believe that independence is a means toward that end. They argue that Social Security, as an entitlement program, should be shielded from short-term partisan politics and bureaucratic infighting, and that administrative independence would enhance public confidence in the program. Critics maintain that administrative independence does little by itself to ensure continuity of leadership or to insulate the agency from politics.

The 1983 Social Security amendments, in keeping with the National Commission's recommendation on agency independence, authorized the establishment of the Congressional Panel on Social Security Organization. The panel was instructed to identify an appropriate method for removing the SSA from HHS and establishing SSA as an independent agency, with its own administrative structure and responsibilities.

The panel recommended to Congress that an independent SSA should be headed by a single administrator, appointed to a statutory 4-year term by the President with the advice and consent of the Senate. It suggested that SSA be responsible for the OASDI and SSI programs only, exclusive of Medicare or Medicaid. To lead the agency, it proposed establishing a permanent, bipartisan advisory board of nine members—five appointed by the President, two by the Senate, and two by the House—to oversee the program and make policy recommendations to the administrator, the President, and Congress.

Sponsors of independent agency proposals often point out that since 1971, SSA has many different Commissioners and HHS has had numerous Secretaries. SSA has been administratively reorganized a number of times in the past decade, resulting in little continuity or long-term coherence in leadership and policy. Ironically, they propose as a cure a proposal to reorganize SSA. Further, advocates point to major policy debacles that have plagued Social Security in the past decade, including the crisis in the SSDI program created by the overzealous implementation of continuing disability reviews, and the retroactive elimination, and subsequent restoration of the minimum benefit. It is contended that with an independent agency, high level leadership would be more sensitive to the integrity of Social Security and more effective in promoting sound policy and administration.

Both the House and Senate Finance Committee proposals for an independent agency which were approved in 1989 required SSA to handle only the Social Security and Medicare programs, leaving Medicare and Medicaid to be handled by HHS. They differed in that the House proposal had a three-member bipartisan board in charge of SSA, while the Senate Finance proposal recommended a single administrator.

Many opponents of an independent SSA argue that conflicts could arise between board members that could impair the agency's efficiency. They add that most agency problems do not result from SSA's location within HHS, but rather result from poor planning and policymaking. Organizational structure may be less to blame than bad leadership, low morale, and voluminous congressional legislation. Some claim that changing the administrative structure will not by itself eliminate policy problems. Improvements can only be accomplished by appointing intelligent and component officials. Opponents believe that while the creation of an independent SSA might alleviate certain management problems, it could just as easily create others. They maintain that SSA's current administrative problems have not resulted from bureaucratic obstacles imposed by HHS, the Office of Personnel Management, and the General Services Administration, but rather than those agencies provide valuable oversight contributions. Some argue that independence would strengthen the hand of the Office of Management and Budget in dominating the agency. Arguments are also made that independence would not necessarily insulate SSA from politics nor insure elimination of the troublesome, frequent turnover of SSA Commissioners. Indeed, Senator Moynihan proposed in 1989 that SSA should be made a cabinet level agency, despite arguments that such a move could politicize the agency.

Many believe that Social Security's impact on the Federal fiscal policymaking agenda is too important to allow the program to escape difficult fiscal choices. They argue that an independent agency would not, and should not, put Social Security above politics and that an independent Social Security Administration would not exist in a political and philosophical void. A board appointed by the President and confirmed by the Senate would not necessarily be politically neutral, nor would a single administrator. It is precisely this type of political influence that advocates of an independent agency seek to avoid. They argue that independence would insulate Social Security programs from short-term fiscal policy decisions that could prove detrimental to the program's long-term efficiency. Others, however, assert that by establishing an independent tribunal with diminished accountability to the President, Social Security would be less accountable to the views of the public, and less subject to reform or revision should that become desirable in the future.

In 1989, the Chairman of the Aging Committee requested a study by the GAO and another by the National Academy of Public Administrator (NAPA) to examine how to structure the leadership of an independent SSA. Both GAO and Harold Seidman, who authored the National Academy of Public Administration study, strongly recommended that a single administrator be appointed rather than a board.

According to GAO, the idea of an independent SSA presents both advantages and disadvantages. GAO believes that independence could enhance the stature of the Commissioner, thereby attracting highly qualified individuals to the job. Such conditions could indeed enhance policymaking and leadership continuity. However, GAO is troubled by the potentially detrimental effects of establishing a governing board. In supporting this position, the agency cites frequent criticisms of the effectiveness of similar boards, including: (1) untimely decisions; (2) interference by board members in the daily operations of the agency; and (3) diffused accountability. GAO believes that confusion could develop regarding whether the President, the Commissioner, or the board would be accountable to Congress and the public. GAO argued that, "in practice, the board form of organization has not proven effective in providing stable leadership, in insulating decisions from political pressures, and in assuring that diverse viewpoints are considered in the decision-making process." Although GAO declines to take a position on whether an independent agency is advisable, they do state that "on balance we do not believe that independence of SSA is essential to solving the serious management problems (at SSA). Independence is not the panacea."

The NAPA study concluded, like GAO, that a single administrator is a superior form of organization to a board for a large executive agency like SSA. Seidman, writing for NAPA, observed, "given the difficulty of maintaining a clear dividing line between policy and administration, few boards are willing to delegate responsibility for day-to-day management and operations to a chief executive officer or to refrain from micromanaging." Decrying organizational responses to management and policy problems, Seidman wrote, "In the final analysis, public confidence in a government agency is determined by what it does, not by how it is organized." Former Commissioner Robert M. Ball in a separate statement issued under the same study by NAPA argued for a board form of organization. While conceding that "if all that were at issue was the efficiency of day-to-day operations, it is probably true that a single head would be a slightly better form of organization," Ball argued that the board was needed to give SSA the appearance of being above politics, "to underline the long-range character and trustee nature of the government's responsibility." He also argued that a board would help prevent abrupt shifts in policy that might lead to undermining confidence in the program.

Advocates of an independent SSA are likely to continue to push for its enactment despite the lack of progress in 1990. It is yet unclear how this can be accomplished given the fierce opposition of the administration. It is also not yet clear whether an appropriate vehicle for enacting this legislation will present itself in 1991.

(F) COMPUTER MODERNIZATION

Although SSA was once a leader in using automation to improve its operations, the last 10 to 15 years have seen its computer systems deteriorate to the brink of disaster. In the early 1980's, this deterioration affected virtually every aspect of SSA's operations, including its organization, management, personnel, and ability to serve the public. In the past decade SSA has made three attempts to upgrade its computer operations, none of which have been completely successful. The current effort, known as the Systems Modernization Plan (SMP), began in 1982. The SMP was intended to improve four major advanced data processing areas at the agency: (1) software and software engineering; (2) hardware, and therefore SSA's capacity; (3) data communications utility; and (4) database integration. The main thrust of this modernization effort was software improvement.

In late 1989, a crisis demonstrated that SSA still has far to go to successfully achieve its systems modernization goals. On November 22, Congress repealed the Medicare Catastrophic Coverage Act, requiring that premiums no longer be deducted from Medicare beneficiaries' Social Security checks. SSA predicted it would not be able to stop charging catastrophic premiums for 5 or 6 months, which meant that nearly 33 million retirees would be overcharged $5.30 a month. SSA's computers could not be reprogrammed more quickly to avoid the overcharges. Senate Aging Committee Chairman Pryor wrote to Commissioner King to request that the overcharges be halted as soon as possible. King assembled a panel of experts, and based on their advice, the Treasury Department planned to issue separate bimonthly refund checks while SSA was reprogramming its computers. Although this solution assisted Medicare beneficiaries in obtaining faster refunds, it added to the Government's expense and increased SSA's overall workload on the project. This episode demonstrated that progress remains before SSA's computer system meets its promises. The refunds were sent by May 1990 at a cost to taxpayers of around $40 million.

While the SMP was originally designed as a 5-year modernization effort (1982–87), the project remains to be finalized. The design, testing and implementation of the computer system will not be completed until some time in the 1990's. According to GAO, this will result in delaying many needed improvements in SSA's existing post-entitlement system.

It is important to note that SSA has made significant progress in certain areas of its modernization plan, including considerable hardware improvements and some software improvements. However, the agency has been criticized for hastily purchasing new hardware before its future needs were fully understood. In addition, crucial software modernization has been sluggish.

SSA's problems have consistently involved inefficient management and organization, as well as a lack of planning for the future. Efforts to improve these inadequacies will take time, especially when considering the continuing threat of administrative budget cuts. However, faced with continued congressional scrutiny, SSA will likely continue improving its modernization effort.

4. BENEFIT ISSUES AND CONGRESSIONAL RESPONSE

Social Security has a complex system of determining benefit levels for the millions of Americans who currently receive them, and for all who will receive them in the future. Over time, this benefit structure has evolved, with Congress mandating changes when it believed they were necessary. A number of specific benefit issues drew the attention of Congress in 1990, including the plight of so-called "deemed widows," the Social Security earnings test, and the "notch."

(A) DEEMED WIDOWS

In 1990, Congress moved to rectify a problem in the Social Security law which had caused many tragic situations over the years for so-called "deemed widows" (or widowers). Deemed widow(ers) are individuals who married in good faith in a ceremonial wedding, but whose marriage is rendered invalid because of a legal flaw in their marriage. Usually, the problem is that the person she or he becomes married to has a preexisting marriage which was not properly terminated in divorce. As a result, the subsequent marriage is legally invalid. Under previous Social Security law, such an individual is considered a "deemed spouse" so that he or she can receive spouse's benefits, such as widow(er)'s benefits. However, if the first spouse appears and applies for benefits, the second deemed spouse loses his or her benefits.

Under the new law, based on legislation promoted by Senators Riegle, Heinz, and Pryor, both the legal spouse and the deemed spouse will be able to receive benefits at the same time. A divorced spouse will also be eligible to be considered a deemed spouse. This major improvement will remedy tragic situations that have come to the attention of Congress, typically involving women who had relied on their spouses for support and who had suddenly became deprived of Social Security benefits when a spouse out of the husband's distant past applies for benefits.

(B) SOCIAL SECURITY EARNINGS TEST

One of the most controversial issues in the Social Security program is the earnings test, which is a provision in the law that reduces OASDI benefits of beneficiaries who earn income from work above a certain sum. Debate over the Social Security earnings test continued in 1990. Proposals emerged from the Senate Finance and Ways and Means Committees in their respective budget reconciliation bills in 1989. Although the provisions were not included in the enacted version of the reconciliation bill because they were stripped in conference committee, liberalization of the earnings test remains high on the Social Security agenda for 1991.

In 1990, Social Security beneficiaries under age 65 had their benefits reduced by $1 for every $2 earned above $6,840, rising to $7,080 in 1990. In 1990, beneficiaries aged 65 to 69 will have benefits reduced $1 for each $3 earned above $9,360, rising to $9,720 in 1991. The exempt amounts are adjusted each year to rise in proportion to beneficiaries who have reached age 70.

The earnings test is among the least popular features of Social Security. This benefit reduction is widely viewed as a disincentive to continued work efforts by older workers. Indeed, many believe that the earnings test penalizes those age 62 to 69 who wish to remain in the work force. Once workers reach age 70, they are not subject to the test. Opponents of the earnings test consider it an oppressive tax that can add 50 percent to the effective tax rate workers pay on earnings above the exempt amounts. Opponents also maintain that it discriminates against the skilled, and therefore more highly paid worker and that it can hurt elderly individuals who need to work to supplement meager Social Security benefits. They argue that although the test reduces Federal budget outlays, it also denies to the Nation valuable potential contributions of older, more experienced workers. Some point out that no such limit exists when the additional income is from pensions, interest, dividends, or capital gains, and that it is unfair to single out those who wish to continue working. Finally, some object because it is very complex and costly to administer.

Defenders of the earnings test say it reasonably executes the purpose of the Social Security program. Because the system is a form of social insurance that protects workers from loss of income due to the retirement, death, or disability of the worker, they consider it appropriate to withhold benefits for workers who show by their substantial earnings that they have not in fact "retired." They also argue that eliminating or liberalizing the test would primarily help relatively better-off individuals who need the help least. Furthermore, they point out that eliminating the earnings test would be extremely expensive. They find it difficult to justify draining the Federal budget by an additional $57 billion over 5 years in order to finance the test's immediate removal. Proponents of elimination counter that older Americans who remain in the work force persist in making contributions to the national economy and continue paying Social Security taxes.

Despite intense legislative activity in the 101st Congress, no earnings test measures were enacted in the final version of any bills. Yet because both Houses of Congress approved some form of a change in the 101st Congress, further legislative activity can be expected next year. Given the high cost of entirely eliminating the earnings test, serious legislative initiatives will continue to propose compromises.

(C) THE SOCIAL SECURITY "NOTCH"

The Social Security "notch" refers to the difference in monthly Social Security benefits between some of those born before 1916 and those born from 1917 to 1921. The difference results from changes in the benefit formula contained in legislation enacted in 1972 and 1977. Differences are substantial primarily for those in the highest benefit levels who defer retirement until age 65.

The Social Security "notch" stems from a series of legislative changes made in the Social Security benefit formula, beginning in 1972. That year, Congress first mandated automatic annual indexing of both the formula to compute initial benefits at retirement and of benefit amounts after retirement, known as COLA's or cost-of-living adjustments. The intent was to eliminate the need for ad hoc benefit increases and to adjust benefit levels in relation to changes in the cost of living. However, the method of indexing the formula was flawed in that initial benefit levels were being indexed twice—for increases in both prices and wages. Consequently, initial benefit levels were rising rapidly in relation to the preretirement income of beneficiaries. Prior to the effective date of the 1972 amendments, Social Security replaced 38 percent of preretirement income for an average worker retiring at age 65. The error in the

1972 amendments, however, caused an escalation of the replacement rate to 55 percent for that same worker.

Without a change in the law, by the turn of the century, benefits would have exceeded a recipient's preretirement income. Financing this increase rather than correcting the over-indexing of benefits would have entailed doubling the Social Security tax rate. Concern over the program's solvency provided a major impetus for the 1977 Social Security amendments, which substantially changed the benefit computation for those born after 1916. To remedy the problem, Congress chose to partially scale back the increase in relative benefits for those born from 1917 to 1921 and to finance the remaining benefit increase with a series of scheduled tax increases. Future benefits for the average worker under the new formula were set at 42 percent of pre-retirement income.

The intent of the 1977 legislation was to create a relatively smooth transition between those retiring under the old method and those retiring under the new method. Unfortunately, high inflation in the late seventies and early eighties caused an exaggerated difference between the benefit levels of many of those born prior to 1917 and those born later.

Although the notch is actually the result of an over-indexing of benefits for those retiring under the old formula, and does not reflect any reduction in real benefits to those retiring under transition rules, it has been perceived as a benefit reduction by those affected. Those born from 1917 to 1921—the so-called notch babies—have been the most vocal supporters of a "correction," yet these beneficiaries fare much better than those born later. Individual Members of Congress have responded to the notch-babies' complaints by introducing a series of proposals for relief, most of which would give benefit increases to those born after 1916.

At a January 1989 hearing of the Senate Finance Subcommittee on Social Security, studies were examined that dealt a severe blow to arguments of unfairness leveled by the notch movement. The GAO testified on a March 1988 GAO report entitled "Social Security: The Notch Issue." The report traces the origin to the over-indexing of the benefits for those born in the period preceding the notch years. Although no position is taken with respect to legislation to compensate notch beneficiaries, the report characterizes these proposals as costly—ranging from $20 billion to $300 billion—and possibly difficult to administer. Assuming the financing of the additional benefits would come from the Social Security trust funds, the ability of Social Security to withstand any economic downturns and to provide benefits for future retirees would be jeopardized.

Also testifying on a recent study with similar findings was the National Academy of Social Insurance (NASI), a nonprofit nonpartisan organization focusing on Social Security and related issues. Robert Meyers, former chief actuary of the SSA and current chair of the NASI study panel, summarized the study's conclusion: "the real problem with regard to this matter is that those persons born before 1917 who worked beyond age 62 after 1978 receive undue windfalls. Those born after 1916 are equitably treated, consistent with the intent of Congress, and receive proper benefit amounts * * *. There is no reason why younger workers should, over the years, pay more taxes to provide windfall benefits to this group." The panel therefore recommended that no legislative action be taken on the notch benefit issue.

Drawing on these reports, the Chairmen of the House and the Senate Social Security Subcommittees, Representative Jacobs and Senator Moynihan, respectively, have gone on record as opposing notch legislation. Nevertheless, the notch babies have thus far not been dissuaded from their campaign to receive compensation for what they passionately contend is unfair treatment. As a result, controversy continued and numerous bills were introduced in the 101st Congress.

As the session of Congress drew to a close in 1990, an amendment addressing the notch issue was offered for the first time on the Senate floor by Senator Tom Harkin of Iowa. The amendment never came up for a vote, however, because the underlying bill to which it was offered was voted as being out of order by the Senate. Although 54 Senators, or a majority of the Senate, voted to waive the Budget Act in order to allow the bill to be considered in order, a 60-vote margin was required, so the motion failed. Nevertheless, the fact that an amendment was offered on the floor will continue to encourage advocates of such legislation and spur new efforts when the next Congress convenes.

(D) SOCIAL SECURITY'S IMPACT ON WOMEN

In 1990, public concerns expressed by women's organizations and Members of Congress generated a new look at how Social Security programs impact women. The concerns have focused on the plight of older women, one of the poorest groups in the country, but also include longstanding issues about women and Social Security.

The Older Women's League issued a report in 1990 raising cncerns about disparities between the genders in Social Security benefits. The House Select Committee on Aging explored these concerns in a hearing and legislation was introduced to amend the way benefit amounts are calculated which would lessen the disparities. SSA Commissioner Gwendolyn S. King established a women's issues internal work group in response to concerns raised.

Although Social Security law is "gender neutral," differences in men's and women's work histories affect their Social Security benefits. In particular, those who elect to provide care to children rather than work full time in wage earning employment are penalized.

Lessening the penalty for years served in dependent care is the focus of legislative efforts on this issue. The debate on this issue had just begun in 1990, and promises to continue as Commissioner King and Members of Congress examine the issue further in 1991.

(E) MISCELLANEOUS AMENDMENTS IN OBRA 1990

A number of provisions affecting Social Security benefits were approved as part of the Omnibus Budget Reconciliation Act of 1990. A brief description of the most important ones not discussed above follows.

One provision waives a 2-year waiting period for independent entitlement to divorced spouse's benefits. Currently, a divorced spouse may apply for old age spouse's benefits on her former spouse's (the worker's) record even if the worker has not applied for benefits, so long as he is eligible for benefits. There is a requirement that the divorce must have occurred at least 2 years prior to the beginning of payment. The new law provides an exception so that this 2-year rule is waived if the worker was entitled to benefits prior to the divorce. According to the conference report on the legislation, "In this way, a spouse whose divorce took place after the couple had begun to receive retirement benefits, and whose former spouse (the worker) returned to work after the divorce thus causing the suspension of benefits, would not lose benefits on which he or she had come to depend."

Another provision reduces the amount of wages needed to earn a year of coverage toward the special minimum benefit. In Social Security, there is a provision which assures a "special minimum" benefit to individuals who worked a long time in covered employment at very low wages. The provision in the new law amends the formula to assure that minimum wage earners can benefit from the provision. It lowers the amount of earnings needed to earn a year of coverage for the special minimum benefit.

Finally, the new law precludes the unintended payment of so-called "Prouty benefits," which were enacted in 1966 to help workers who were too old to earn sufficient quarters of coverage to qualify for regular benefits. Because of subsequent amendments to the law, it is possible for some workers to qualify for Prouty benefits after 1990 even though, when enacted, they were not expected to be paid to anyone who reached age 72 after 1971.

5. Social Security Tax Issues

(A) PAYROLL TAX RATES AND THE MOYNIHAN PROPOSAL

Senator Daniel Patrick Moynihan's proposal to reduce Social Security payroll tax rates captured far more attention than did any other Social Security issue in 1990. It sparked the most heated and widespread debate about Social Security financing since the 1983 amendments placed the system on a solid financial footing.

Moynihan called for an end to the practice of using trust fund reserves to finance the budget deficit. The Bush administration strongly opposed the tax cut plan, proposing instead to retain Social Security revenues and outlays in the Gramm-Rudman-Hollings deficit calculations, while using Social Security surpluses amassed after 1993 to retire publicly held national debt. The specifics of the administration's plan, prepared under OMB Director Darman's direction, were never taken very seriously.

The underlying rationale for the tax cut proposals is that Social Security tax rates are higher than needed to meet today's Social Security costs, which are consuming only about 85 percent of the combined employer and employee contributions. Senator Moynihan is proposing to bring the rate more in line with actual costs, returning the system to a "pay-as-you-go" basis. Under the current financing system, as enacted in the 1983 amendments, large reserves will develop until around 2015, when the retirement of "baby boomers" will require expenditures to outrun receipts. The Moynihan proposal envisions financing the baby boomers' retirement needs by having tax rate increases scheduled in the law for the next century.

Support for tax cut proposals arises from the belief that surplus taxes are masking the Federal deficit and are not being saved for the future. Although under the 1990 budget agreement Social Security is taken off-budget and therefore does not "hide" deficit numbers, in fact the actual reserves are used in the same fashion to finance current Federal outlays. Supporters argue that Social Security taxes are a regressive and dishonest method of financing deficit spending, and some see the tax cut as a means of forcing Congress and the administration to consider an alternative tax structure, such as raising income taxes. Some argue that politicians cannot be expected not to spend surpluses if they are allowed to continue, and the only way to enforce fiscal discipline is to remove surpluses. They argue that by eliminating the surpluses, the public gains a clearer perception of the system's long-run costs. Some proponents see the proposal as an opportunity to score political points with a working class constituency, contrasting it with the administration's push for a capital gains tax reduction. Fundamentally, many believe that it is wrong to finance general government expenditures with taxes raised for Social Security purposes, and that this robs the widespread support for the Social Security system to pay for irresponsible deficit spending.

Critics of tax cut proposals point out that without making up for the revenue loss, an immediate tax reduction would increase the Government's borrowing from the public, thereby reducing the amount of resources available for private investment. It would impair the Nation's savings rate, rather than bolster it to prepare for the demands of the next century. They contend that the surplus receipts allow the Government to borrow less, and insist that any tax cut be accompanied by offsetting revenue increases. Many are concerned that if a tax schedule was enacted to achieve a pay-as-you-go system but proved inadequate because of faulty assumptions, the system's financial solvency could be threatened, eroding public confidence and undermining the benefit structure. Some advocates contend that no tax cut should be made until larger reserves are built up in the trust funds.

A series of three hearings were held in the Senate Finance Committee in February 1990. The hearing records provide a good display of the prevalent arguments for and against the proposal. Also in early 1990, the Chairman of the Senate Budget Committee proposed to tie cuts in Social Security taxes to deficit reduction targets. Chairman Jim Sasser proposed to replace the Gramm-Rudman-Hollings penalty of a sequester in the event Congress fails to reach deficit targets with the reward of a rollback of Social Security taxes when Congress reaches the new targets set in his proposal.

One of Senator Moynihan's bills to cut Social Security taxes, S. 3167, was debated in the Senate on October 9 and 10, 1990. Senator Ted Stevens raised a point of order against the bill because it violated the budget resolution which had recently been approved by Congress. Senator Moynihan moved to waive the point of order, which required 60 votes to waive. 54 Senators voted to waive the point of order. Although this was a majority of the Senate, it was insufficient to waive the point of order, effectively ending consideration of the bill. 42 Democrats and 12 Republicans voted to waive the point of order, while 44 voted against, including 13 Democrats and 31 Republicans.

Senator Moynihan is continuing his efforts to enact a tax cut in 1991. Although new rules that were enacted under the budget agreement in 1990 will complicate the legislative strategy, he finds it encouraging that a majority of the Senate voted to waive the point of order last year.

(B) TAXATION OF SOCIAL SECURITY BENEFITS

During the intense negotiations of the 1990 budget summit between the White House and Congress, the issue of cutting or taxing Social Security benefits was raised occasionally, with great trepidation. It became clear that actually cutting benefits or delaying COLAs in the popular program was politically impossible.

A more frequent proposal, which was considered more seriously than cutting benefits, was to tax benefits at an increased rate over current law. Although this proposal was not adopted, it was considered by some to be preferable because it would not affect lower-income beneficiaries. Specifically, proposals were made to increase the amount of Social Security benefits subject to income taxation from 50 percent under current law to 85 percent. The current income thresholds to be subject to that tax, which were not proposed to be changed, are $25,000 for singles and $32,000 for couples.

According to news reports, this proposal was not adopted because the budget summit negotiators believed the political opposition it would cause was not worth the amount of revenue it raised. The proposal can be described by two of the most deadly words in the American political lexicon: "tax" and "Social Security." Politicians are likely to continue to steer clear of this highly charged issue.

(C) OASDI EXPANSION TO STATE AND LOCAL GOVERNMENT EMPLOYEES

As a part of the OBRA 1990, employees of State and local governments who are not covered by a public retirement system will be covered by Social Security and Medicare. This would require them to pay payroll taxes under the new law. Students who are employed by public schools, colleges, and universities are excluded from the requirement. The provision is expected to raise $9.2 billion in revenue over 5 years.

(D) RECOVERY OF OVERPAYMENTS

Under a provision of OBRA 1990, SSA will be permitted to recover overpayments from former beneficiaries by withholding amounts due from Federal income tax refunds through arrangements with the Internal Revenue Service. The provision will remain in effect at least until January 1994. These individuals generally have not complied with SSA requests to remit overpayments. The provision is expected to save $160 million over the next 5 years.

B. SOCIAL SECURITY DISABILITY INSURANCE

1. BACKGROUND

In 1990, Congress continued to supervise SSA's implementation of the largest national disability program, Social Security Disability Insurance (SSDI). Concern about abuses by SSA in the early 1980's led to reforms that were enacted by the Social Security Disability Reform Act of 1984 (Pub. L. 98-460). Congress continues to oversee SSA's implementation of that legislation. In 1990, Congress carefully monitored the program to ensure that new patterns of disregard for beneficiaries could be identified and quickly remedied.

In particular, the Senate and House Aging Committees and other Members of Congress scrutinized the standards and the process SSA used to review the eligibility status of SSDI beneficiaries. Hearings held in both Committees, and an investigative report by the Senate Aging Committee, uncovered disturbing trends. Budget shortfalls forced the agencies responsible for disability determinations to take shortcuts, delay responses, and go without needed medical evidence which might have assisted them to make fairer decisions. The Senate investigation also identified increases in delays and mistakes which resulted in serious cases of deprivation and human suffering.

On the legislative front, in 1990 an impressive series of legislative reforms affecting SSDI was enacted in the OBRA 1990.

Chairman Pryor in 1990 sought to ensure that citizens seeking disability insurance had access to fair evaluations of their conditions, and, if necessary, impartial hearings with administrative due process. In addition to working to improve the disability determination process, he promoted legislation designed to improve the management of the hearings and appeals process at the SSA. Legislation he introduced was enacted to reform the attorney fee process, which is intended to ensure that Social Security claimants are strongly represented at fair and speedy hearings.

(A) RECENT HISTORY

Since the inception of SSDI, SSA has determined the eligibility of beneficiaries. In response to the concern that SSA was not adequately monitoring continued eligibility, Congress included a requirement in the 1980 Social Security amendments that SSA review the eligibility of non-permanently disabled beneficiaries at least once every 3 years. The purpose of the continuing disability reviews (CDRs) was to terminate benefits to recipients who were no longer disabled.

The new law was to go into effect in 1982. However, on its own initiative in early 1981, SSA accelerated the implementation of the reviews, increasing its monthly review workload by an additional 30,000 cases. As a result, between March 1981 and April 1984, 1.2 million case reviews were completed and close to 500,000 beneficiaries were determined to be no longer eligible for DI benefits.

Not long after the CDRs were implemented, widespread concern arose about the quality, accuracy, and fairness of the reviews. Many States, on their own initiative or by court order, declared moratoria on the reviews, or began administering the CDRs under guidelines that differed from SSA's official policy. By 1984, more than half the States were either not processing CDRs, or were doing so under modified standards.

In that same year, after extensive hearing and debate over numerous competing proposals, Congress enacted the 1984 Social Security Disability Benefits Reform Act to restore order, fairness, and national uniformity to the SSDI program. The main reform required SSA to prove that a beneficiary's medical condition had improved from the time of the initial disability determination. Under that mandate, SSA created new standards for evaluating disabilities caused by mental impairments, created guidelines for the determination of medical improvement as a prerequisite to the termination of benefits, and revised the medical criteria applicable to the determination of a physical disability.

Although this subsided the controversy, Congress continues to closely monitor the program. More recently, SSA has drastically cut back on CDRs, partly due to budget shortfalls that have left it unable to meet the mandated requirements for the number of CDRs it must perform. In addition, in 1990, Congress uncovered evidence of a deterioration in the quality of disability determinations being conducted by SSA.

2. Issues and Congressional Response

(A) DISABLED WIDOWS/WIDOWERS

The largest change in the Social Security benefit structure enacted in 1990 amended the eligibility standard for disabled widows and widowers. The provisions repealed the stricter definition of disability long applied to these individuals. Based on legislation introduced by Senator Heinz, disabled widows will not qualify under the same definition of disability that is applied to all other disabled individuals. Prior to this change, a more stringent test of disability resulted in the denial of benefits to approximately 5,000 applicants each year.

The previous, more restrictive test that had to be met to establish eligibility for widows/widowers benefits was that they could not engage in "any gainful activity." This meant that they had to be completely incapacitated to the extent that no work whatsoever could be accomplished. This standard was repealed in favor of the same test that other workers must meet, which is that they cannot engage in "substantial gainful activity," currently defined by regulation as $500 per month.

This landmark legislative provision removes a major inequity in the Social Security program, and will assist many thousands of deserving older Americans in the future.

(B) DISABILITY DETERMINATION PROCESS

In 1990, Congress focused attention on problems that were becoming apparent with SSA's disability determination system. Hearings were held in both Senate and House Aging Committees, and the Senate Aging Committee conducted a bipartisan investigation which culminated in a report to the Committee.

Congress has long been interested in these issues because determining if a citizen is disabled for purposes of the SSDI programs is among the most difficult and sensitive tasks of the Federal Government. Mistakes can have tragic consequences, exposing people who have worked their whole lives until becoming disabled to starvation, loneliness, or other deprivations. While the system must respond to the needs of individuals with disabilities, it cannot afford to casually award benefits without careful scrutiny.

The investigation by the Special Committee on Aging revealed that SSA's disability determination system is erring on the side of bureaucratic injustice: individuals who are disabled are being denied benefits. Many of those denied, rightly or wrongly, simply accept the decision and seek the assistance of family and friends. Others, convinced that they are disabled with nowhere else to turn, appeal unfavorable decisions, only to wait months or years to win their benefits.

For example, 64-year-old Mrs. Rita Hartley testified at an Aging Committee hearing in July 1990, that her body wasted away without food or medical care while awaiting benefits on appeal. Fifty-seven-year-old Ms. June Herrin testified that she became homeless and slept in the back of her car while appealing her denial of benefits. She won her appeal 16 months later, after three separate rejections by SSA. All this followed a heart attack and three heart-related trips to the hospital.

The Senate study identified a severe budget crisis facing the Disability Determination Services (DDSs), which are administered by the States for SSA. The majority of State DDS directors stated in a survey that they had inadequate funds to perform their duties properly. Budget shortfalls forced the DDSs to take shortcuts, delay responses, and go without needed medical evidence which might help them make fairer decisions.

The study found that these problems leave the DDSs in the tenuous position of doing little more than crisis management. The survey of the State disability determination directors shows that 72 percent of the States do not have adequate staff to process their caseloads in a timely manner and that the situation is growing progressively worse. Many disability examiners are now forced to cut corners, eliminating all consultative examinations and discontinuing any reviews of pending Continuing Disability Reviews (CDR) cases.

Unfortunately, the impact of staff reductions implemented during the 1980's, inadequate budgetary resources, and the sheer administrative complexity of the disability determination process have left the system unable to properly fulfill its mission. When these factors are considered, and combined with the impact of a recent Supreme Court decision requiring SSA to re-evaluate hundreds of thousands of children's disability claims—claims which the Court ruled SSA had unjustly denied in the first place—the threat looms of the entire disability determination process becoming overwhelmed. These factors are resulting in increased delays and errors for individuals of all ages who apply for benefits.

According to SSA's own studies, while the number of people who received benefits in error has not changed appreciably, the number of people who are denied in error has increased by over one-third in the last 5 years. During that same time period, processing times for Social Security cases have gone up by 32 percent.

SSA in late 1990 requested permission from the Office of Management and Budget (OMB) to draw upon its contingency fund to meet the pending crises, but the response from OMB has been only minimally supportive. Following a July 1990 letter from Chairman David Pryor of the Senate Aging Committee and an August 1990 letter from Senators John Heinz, Donald W. Riegle, Jr., and Pryor along with 19 other Senators, OMB Director Richard Darman agreed to release only $5 million. This sum is only one-tenth of the original $50 million that was requested by SSA and was insufficient to address the pressing needs of the State DDSs. Yet, the funds were critical to keep DDS's functioning through the end of the year.

The Senate study noted that a lack of uniformity among the different levels of adjudication raises questions about the decisional accuracy and fairness of the process. Currently, 7 out of 10 applicants for disability benefits are now denied at the level of the initial claim. For those who go on to appeal those initial denials, however, 6 out of 10 are later awarded benefits either by an ALJ, the Appeals Council or after remand by Federal courts.

Similar concerns about accuracy were raised following reports from the GAO that 58 percent of those denied disability benefits were still not working 3 years later. The fact that denied applicants had similar health problems to those who had been awarded benefits suggests that they may have been incorrectly denied.

SSA field office procedures are also creating problems. Instead of providing personal assistance, SSA has emphasized the use of telephone claims and self-help applications for those applying for disability benefits. While these were designed to save SSA staff time, significant evidence shows that these methods are not helping claimants.

The Senate report's primary recommendation is that SSA establish a system for interviewing applicants on a face-to-face basis to solicit information and improve the accuracy of decisions. This should be accompanied by an elimination of the reconsideration stage of the appeals process, which many experts have argued is extraneous and only serves to lengthen the process unnecessarily. Given the current budget problems, however, SSA is in no position to implement new responsibilities. While eliminating a step in the bureaucracy might go part of the way toward making funds available for face-to-face interviews, new resources will be required to restore the fairness that Congress originally intended when enacting the disability program.

In order to implement the report's recommendations, Senators Heinz and Pryor joined with others to introduce S. 3131, a bill to reform the disability determination process. The primary feature of the bill is to provide face-to-face interviews for certain disability applicants in the initial stage of the determination process. The particular disabilities which would be subject to the new procedures are the most common ones denied at the initial review and later allowed by ALJs. They include mental, cardiovascular, and musculoskeletal impairments. As the Aging Committee report recommends, the reconsideration stage would be eliminated.

The concerns that were raised and documented in Congress in 1990 continue unabated into 1991. Legislation to implement the study recommendations will again be introduced, and close scrutiny can be expected to continue until SSA brings the problems which have been identified under control.

(C) HEART DISEASE AND SSA'S USE OF TREADMILL TESTS

In a major court decision in June 1990, the Second Circuit Court ruled that SSA was violating the Social Security Act by its heavy reliance on the results of treadmill exercise tests in determining whether a person's heart disease is disabling. Meanwhile, SSA had been moving in exactly the opposite direction. In February 1990, SSA sent a draft notice of proposed rulemaking to HHS Secretary Louis Sullivan for approval which would significantly expand its reliance on treadmill test results for cases in which the applicant or beneficiary has ischemic heart disease. Even after an Aging Committee investigation had uncovered the draft notice, SSA officials insisted that they intended to promote that policy, setting the framework for a confrontation with Congress in 1991.

SSA uses the treadmill test in two ways. First, in determining whether the person has a listed impairment, if the person has had a treadmill test, SSA will rely on its results even if other tests have also been performed and those tests indicate that the person has ischemic heart disease. Second, if the person is determined not to have a listed impairment, SSA uses the treadmill test results to determine the person's residual functional capacity. It was SSA's exclusive reliance on the treadmill test that the Court determined violates the Social Security Act.

The Court concluded, based on expert testimony, that the treadmill test was unreliable, and that overreliance on the test interfered with proper diagnosis of the illness. In particular, an American College of Cardiology study concluded that misdiagnosis of ischemic heart disease occurred in more than one third of cases. Further, other tests which are available are considered more reliable.

Under the draft regulation, SSA proposes to purchase treadmill tests for all individuals with ischemic heart disease who have not taken the test in the past 12 months. According to the memo, while SSA would spend $1.4 million per year to purchase the tests, it expects to save $335 million in 1995 alone in benefits which would have otherwise been paid to individuals who would have been determined to be disabled.

The large sums of benefits involved suggest the magnitude of the issue raised by SSA's proposed rule. If SSA were to publish and continue promoting the rule in 1991, it would undoubtedly raise the ire of key Members of Congress, cause a certain degree of embarrassment for SSA due to continued negative publicity, and undermine public confidence in the fairness of the disability programs. While SSA officials have stated their determination to promote the rule, it is possible that these political and policy problems may cause them to reconsider.

(D) PERMANENT EXTENSION OF INTERIM BENEFITS

Since 1983, a DI beneficiary who has been determined to be no longer disabled has been able to elect to continue receiving benefits, and thus medical care under Medicare, while appealing his or her case before SSA's administrative appeals system. Each year, SSA reviews the cases of thousands of disabled workers. A significant number of these reviews yield adverse decisions, many of which are appealed and ultimately reversed. If the earlier unfavorable determinations are upheld by an ALJ, the benefits are subject to recovery by SSA.

The payment of benefits upon appeal through the hearing stage has been authorized on a temporary basis, but has been continually extended since 1983. The provision was due to expire on December 31, 1990, but was extended permanently by the OBRA 1990. In 1989, the House budget reconciliation bill had proposed making the provision permanent, but the conference committee only agreed to a 1-year extension. The new provision signifies the strong congressional support for the protection it provides to beneficiaries. Without the provision, a decision to terminate benefits at the initial level would take immediate effect, regardless of whether that decision was later ruled incorrect. Although back payments would be provided in such cases, the absence of benefits in the interim would pose a severe hardship to many disabled workers and their families.

Prior to the 1983 law authorizing interim payments, hundreds of thousands of disabled persons abruptly found themselves without any means of support or medical care as a result of the unprecedented number of SSDI terminations in the early eighties. Originally mandated for 1 year, in 1984, Congress extended the provision in 1987, 1988, and again in 1989. In the future, the fate of the provision will not be uncertain as it has in the past.

(E) ATTORNEY FEES

The issue of Social Security attorney fees had been engulfed in controversy in recent years. In 1990, the issue was put to rest by the enactment of legislation deregulating the attorney fee process. The provision was enacted as part of the OBRA 1990. It was based on a bill introduced in 1989 by Chairman Pryor, S. 1571, that was designed to take a consensus approach to streamline the process for awarding fees to attorneys in Social Security cases.

After a somewhat heated dispute between attorneys and SSA in 1987, S. 1571 found a common ground with important improvements for all parties involved. Most importantly, the bill contained provisions to ensure that Social Security claimants will be able to secure representation by attorneys in hearings before SSA, which is fundamental to a full and fair hearing. It was first approved in 1989 by the Senate Finance Committee in its markup of the budget reconciliation bill, but was not included in the final package. In 1990, it was approved by both Houses and signed into law.

From the standpoint of a disabled worker, severe mental or physical conditions can make a complex adjudicative process especially intimidating and confusing. Not surprisingly, disability claimants are increasingly turning to attorneys for assistance. Currently, about two-thirds of claimants appealing decisions to an ALJ are represented by attorneys.

Underlying the issue of attorney fees is the challenge of ensuring adequate safeguards against overcharges while providing fair compensation for services performed on behalf of the claimant. Disability attorneys and SSA agree that the current payment system is cumbersome, drawn out, and in need of reform. The new attorney fee legislation is designed to balance safeguards against the need for fair compensation, while streamlining the process for awarding fees.

In 1987, a battle over attorney fees ensured between SSA and Social Security attorneys. ALJs have responsibility under current law for reviewing fees charged by attorneys in cases argued before them. On April 1, 1987, a new SSA policy temporarily denied ALJs the authority to approve fee requests above $1,500. Previously, an ALJ could approve fees up to $3,000. The basis for this action, according to SSA, was a report of the Inspector General (IG) which concluded that attorney fees were sometimes excessive and should be lowered to a set rate.

Following the start of the new policy, many DI attorneys protested that the new policy would deny them adequate compensation, and that payments would be further delayed and complicated as a result of an additional layer of bureaucracy. They argued that disability claimants would be the ultimate losers because fewer and fewer attorneys could be willing to represent them.

Opposition to the new SSA policy rapidly intensified. The result was enactment of a provision in the OBRA 1987 to rescind the new SSA directive and impose a moratorium until July 1989 on changes to the original payment policy pending the completion and consideration of studies by SSA and GAO.

The GAO report completed pursuant to OBRA 1987 found that generally fees for attorneys were not unreasonable. According to the report, 93 percent of the fee requests up to $3,000 were approved, as was 94 percent of the total amount requested. In most cases, only fee requests exceeding $3,000 were significantly reduced.

However, GAO found that the approval process on average took about 7 months and recommended to SSA a proposal to streamline the process, which SSA has yet to complete. Despite these delays, GAO found that claimants did not have difficulty finding an attorney to represent them. The GAO findings on access, however, are of limited utility because they do not look at different categories of cases where concerns have been raised about the lack of private representation, such as cases in which little or no back award can be expected from which to draw fees. Moreover, GAO's conclusion on access is based on a flawed IG study in which only claimants were interviewed, ignoring the potentially large population who did not appeal because of difficulty in securing representation.

SSA later completed a study, as required by OBRA 1987, which recommended near-total deregulation of the attorney fee process, with a two-party check to the attorney and claimant in each case, which would allow them to work out any arrangement they chose. SSA further proposed that fee disputes be given special scrutiny and that special rules of conduct for representatives appearing before SSA be delineated to ensure that claimants were protected in the process of deregulation.

The provision in OBRA 1990 and S. 1571 took both the SSA and GAO study findings into account. It promoted the goal stated in the SSA study to "relieve both the agency and attorneys of a growing administrative burden." Congress did not, however, go as far in the direction of deregulation as SSA had sought. Yet it moved in the same direction envisaged by the SSA study. The provision drew the line by setting boundaries for fees that can be presumed to be reasonable and proposed that SSA evaluate each fee that falls outside those boundaries. The bulk of all fees can be automatically approved under the new rule, eliminating a huge and unnecessary workload for attorneys and SSA. The legislation will enable SSA to redirect its work force to address growing backlogs of cases.

Under the previous law, when Social Security beneficiaries were represented by an attorney in pursuing an appeal of an unfavorable decision before the agency, the attorney was required to have his fee approved by SSA. If the fee was approved, SSA directly made payments to the attorney out of any past due benefits, but not more than 25 percent of past due benefits.

In cases where the beneficiary's back award was subject to offset for repayment of SSI benefits or State assistance, SSA's policy was to apply the offset before paying the attorney fee. In practice, this resulted in many cases where there were no funds left to pay the attorney. Similarly, in cases where no back benefits accrued because interin benefits were paid, or where no benefits accrued per se, such as representative payee disputes, Medicare eligibility, or disputes about overpayments, funds were often unavailable for appropriate fees.

A version of S. 1570 was approved by the Senate Finance Committee in its markup of the OBRA 1989. Although the provision was dropped as part of the bipartisan agreement to strip the bill of non-budget-related items, it pointed in the direction Congress took in 1990.

Under the new law, in most cases, the current fee petition process will be replaced by a streamlined procedure. Fee agreements under which the attorney will be paid up to a limit of 25 percent (not to exceed $4,000) of the back award will be honored, unless the claimant or the ALJ objects. SSA is given the authority to increase the fee maximum to keep pace with inflation. The current fee petition process remains in place for cases where the fee sought exceeds the limits. An ALJ or other adjudicator may object to the fee agreement "only on the basis of evidence of the failure of the person representing the claimant to represent adequately the claimant's interest or on the basis of evidence that the fee is clearly excessive for services rendered." If a claimant is found to be entitled to both Social Security and SSI, such that a State would be reimbursed for interim assistance provided to the claimant, SSA must first determine and set aside the amount of the fee owed to the attorney before reimbursing the State from the back award.

The new law should set to rest the controversy that has surrounded this issue in recent years.

(F) AN INDEPENDENT APPEALS PROCESS

Chairman of the Aging Committee David Pryor introduced a bill in the 101st Congress, S. 1571, to ensure the independence of the administrative appeals process within SSA. The bill was designed to ensure the independence of ALJs at SSA so that they remain free to make decisions on Social Security cases without political interference. The bill was intended to structrually prevent the problems of the early 1980's, on which the Aging Committee has built a significant record attesting to an assault on thousands of truly disabled Americans who could not argue their case, and a threat by SSA on the independence of ALJs who sought to correct such abuses.

The independence of the appeals process is integral to the Social Security program. SSA is required to conduct hearings to consider appeals of SSA decisions by claimants for benefits. Hearings are conducted by ALJs, who are located organizationally within the Office of Hearings and Appeals, headed by an associate commissioner who reports to the Commissioner of SSA. S. 1571 is designed to prevent ALJs from being subjected to political pressure to save program dollars at the expense of eligible beneficiaries.

ALJs hear and decide cases arising within the jurisdiction of the Department of Health and Human Services, including Medicare and Social Security. The judges are theoretically organized under a chief ALJ. The position is not a creation of either statute or regulation, making it an ineffective office. The actual authority resides in the Associate Commissioner and the Deputy Commissioner and to whom the Associate Commissioner reports.

A series of congressional hearings in 1975, 1979, 1981, 1982, 1983, and 1988 on the appeals process at Social Security have documented that bureaucratic interference has sometimes threatened the due process rights of claimants. In 1982, the Aging Committee joined with the Government Affairs Committee to hold a field hearing in Fort Smith, AR, which provided evidence that such abuses had been occurring. A problem with the current structure is that responsibility for the entire hearing process is placed upon individual ALJs, but the managerial authority for the program is in the hands of non-legally trained bureaucrats who have sometimes been insensitive to the rights of claimants. In the 1984 case of *Association of Administrative Law Judges* v. *Heckler*, a Federal district court held that the SSA had an ulterior motive in the continuing disability review program to reduce the payment of claims by ALJs and the judges could have reasonably felt pressured to issue fewer allowance decisions.

Although S. 1571 was not enacted in 1990, it was adopted in 1989 by the Senate Finance Committee as part of a proposal it approved to make SSA independent of HHS. This legislation proposed to replace the current arrangement of the OHA with the appointment under a special nonpartisan process of a chief ALJ to administer hearings and appeals. A chief ALJ would be appointed to administer the hearings and appeals process, reporting directly to the Commissioner of Social Security. The chief ALJ would be appointed by the Secretary pursuant to recommendations made by a special nominations commission established for that purpose. The Secretary would invite the participation of the President of the American Bar Association, the Federal Bar Association, and the Chairman of the Administrative Conference of the United States, or their respective designees, and other such representatives as the Secretary considered appropriate. The nominations commission would recommend three choices. Then the Commissioner of Social Security would either make a selection, request a new list, or be required to explain to Congress the reasons for not doing so. The nominee must have been an ALJ for at least 3 years preceding his appointment. The chief ALJ would serve for a fixed term of 5 years and may be removed only pursuant to a finding by the Commissioner of neglect of duty or malfeasance in office.

The approach taken in S. 1571 is now considered a vital component of any proposal to make SSA an independent agency. In 1990, the proposal to make SSA independent was put on the shelf because of its controversial nature. Future such proposals can be expected to contain provisions to ensure the independence of ALJs and the appeals process. The final outcome can be expected, like S. 1571, to keep the office under SSA, but to accord it greater independence and stature within the agency. In 1991, a proposal like S. 1571 may be promoted outside the context of the independent agency debate. It could be enacted within the current structure of SSA. Confidence in the appeals system would be increased by placing the process under the operational control of a chief ALJ.

C. PROGNOSIS

The 1983 changes ~~in~~ Social Security financing are widely regarded as having ensured the solvency of the system well into the next century. However, the same law that appears to have restored fiscal health to Social Security also set into motion rapidly building reserves that are creating controversy while being used to finance the Federal budget deficit.

In 1990, the removal of Social Security trust funds from the budget was the central accomplishment resulting from the new attention that was being paid to Social Security financing. Now that this is accomplished, congressional attention in 1991 will focus on the question of Social Security tax rates. Congress will confront questions of how the growing reserves in the trust funds should affect the national savings rate and the Social Security tax structure. With a growing recession at the outset of the year, tax cut pressures will rise to stimulate the economy. At the same time, after 1990's mammoth efforts to reduce the budget deficit, congressional leaders will be wary of increasing Federal demands on the Nation's capital. In addition, new rules enacted as part of that budget deal emphasize the need to provide revenues to offset the revenue loss caused by the tax cut. Politically, however, the burden of new taxes on top of the tax increases in 1990's budget package would make the tax cut proposal look less attractive. Undoubtedly, the tax cut proposal will engender the most colorful and wide-ranging Social Security debate in 1991.

Social Security emerged unscathed from efforts in 1990 to cut the budget deficit. Once again, the program demonstrated its popularity and the strength of its constituency. Because the 1990 budget agreement lasts 5 years, and because such a large effort to bring down the budget deficit is unlikely to be repeated any time soon, Social Security is likely to continue to avoid being a target of budget cuts. The fact that it remained off the table in 1990 may mean that congressional and administration leaders have learned the lesson that Social Security is not part of the deficit problem and should be treated apart from the rest of the Federal budget. Even if some political leaders sought to use Social Security to balance the budget, the growing public awareness of the flaw in that approach militated against benefit cuts.

In fact, 1990 proved to be a banner year in Social Security because of the number of positive reforms that were enacted as part of the budget package. Pressures that had mounted enact Social Security provisions that were dropped in 1989 were released by 1990's accomplishments. As a result of so many pressing issues having been addressed in 1990, fewer items remain on the agenda for 1991. The Chairman of the Finance and Ways and Means Committees proved themselves in 1990 to be effective and concerned stewards of the Social Security program. This bodes well for continued success in 1991.

Despite the progress in 1990, a number of issues remain on the agenda for 1991. These include proposals for earnings test increases, reorganization of SSA as an independent agency with an independent appeals process, certain SSA services improvements, reform of the disability determination process, Social Security's impact on women, and other important program improvements. On the bulk of these issues, both the House and Senate have significant legislative histories in 1990. The challenge in 1991 will be to build a consensus among both Houses.

Significant differences between the House and Senate approaches in the 101st Congress remain to be resolved in the 102d Congress. The Senate-approved earnings test change was far more liberal than the House version. The House and Senate also differ on the proposed leadership and organizational structure of an independent SSA. Evidence compiled by the Special Committee on Aging suggest those differences should be resolved largely in favor of the Senate's approach. The administration will fiercely resist any attempt to divorce SSA from HHS, complicating its likelihood of passage.

Congress will also be busy in 1991 consolidating the legislative achievements of 1990. Careful scrutiny will be given as to how SSA implements the new law requiring SSA to provide the public telephone access to their Social Security office. In addition, Congress will oversee how SSA implements the complicated and far-reaching legislation reforming the representative payee system. A number of improvements in SSA's public service were enacted which will require congressional oversight. These and other legislative initiatives will require resources that SSA is in a poor position to provide. Congress will be obligated, therefore, to evaluate SSA's budgetary needs on the context of the new demands made by Congress in 1990. Clearly, SSA is faced with an inadequate budget for its administrative needs in 1991, and Members of Congress may face the need to intervene to prevent a serious breakdown in the program's services.

Regarding the SSDI program, it appears clear that the 1984 reforms have largely succeeded in halting the abusive administrative practices in the continuing disability review process that occurred in the early eighties. However, as a more complete and accurate picture of current problems came into view as a result of congressional hearings and investigations in 1990, a number of recommendations emerged toward the end of that year. In 1991, Members of Congress, and the leadership of the Aging Committees, will promote these reforms until Congress is convinced that fair treatment of those entitled to benefits under the SSDI program is realized. In addition, congressional committees will carefully follow the progress of the disability determination services in light of the budget problems that were discovered in 1990. If Congress is shown a convincing record that SSA is not arbitrarily denying benefits to those who meet intended eligibility requirements, it would become more receptive to critics who inevitably point to abuses of the system. The challenge facing Congress and SSA is to strike a balance which fully addresses both of these concerns.

As the progress made in 1990 attests, the Social Security system retains the overwhelming support of the general public, the elderly and many in the Congress. Given this support and adequate current financing, Social Security may be expected to continue on a stable path in the coming years.

Chapter 2

EMPLOYEE PENSIONS

OVERVIEW

Many employees receive retirement income from sources other than Social Security. Numerous pension plans are available to employees from a variety of employers, including companies, unions, Federal, State, and local governments, the U.S. military, National Guard, and Reserve forces. The importance of the income these plans provide to retirees accounts for the notable level of congressional interest in recent years, which culminated in massive pension reforms during 1986.

Largely because of 1986 reforms, the Congress has enacted no new major revisions of the laws affecting pensions since that time. Indeed, most of the major retirement income policy issues that were debated in recent years had been either fully or partially resolved by the legislation. However, there were some exceptions.

In 1987, Congress strengthened the requirements governing employer contributions to defined-benefit plans, in order to assure adequate levels of assets for employee pension benefits. In 1990, Congress made a number of substantial changes to the rules governing asset reversions from over-funded pension plans and increased Pension Benefit Guarantee Corporation (PBGC) premiums for employers.

A. PRIVATE PENSIONS

1. Background

Employer-sponsored pension plans provide many retirees with a needed supplement to their Social Security income. Most of these plans are sponsored by a single employer and provide employees credit only for service performed for the sponsoring employer. However, a small number of private plan participants are covered by multiemployer plans which provide members of a union with continued benefit accrual while working for any of a number of employers within the same industry and/or region. As of 1990, 50 million workers and retirees were covered by an employer-sponsored pension plan. Employees of larger firms were far more likely to be covered by an employer-sponsored pension plan than were employees of small firms. According to 1990 data, private pension funds totaled $2 trillion. In 1988, pension plans owned $566 billion in equities, 18 percent of all equities in the United States.

Most private plan participants are covered under a defined-benefit pension plan. The remainder participate in defined-contribution pension plans. Defined-benefit plans specify the benefits that will be paid in retirement, usually as a function of the worker's years of service under the plan or years of service and pay. The employer makes annual contributions to the pension trust based on estimates of the amount of investment needed to pay future benefits.

Defined-benefit plans generally base the benefit paid in retirement either on the employee's length of service or on a combination of his or her pay and length of service. Fewer than a third of all participants in medium and large private plans receive benefits based on a fixed dollar amount for each year of service. Most fixed dollar plans cover union or hourly employees and are collectively bargained between the union and employer. The majority of pension plan participants are in salary-related plans that base the benefit on a fixed percentage of career average pay or the final 3 or 5 years of pay.

Workers in private-sector defined-benefit plans are typically in large primary pension plans funded entirely by the employer. More than three-quarters of the participants in the defined-benefit plans are in plans with more than 1,000 participants. The largest employers generally supplement their defined-benefit plan with one or more defined-contribution plans. Where supplemental plans are offered, the defined-benefit plan is usually funded entirely by the employer, and the supplemental defined-contribution plans are jointly funded by employer and employee contributions. Defined-benefit plans occasionally accept voluntary employee contributions or require employee contributions. However, fewer than 3 percent of the contributions to defined-benefit plans come from employees. Most of those contributing to their pension plans are government employees.

Defined-contribution plans, on the other hand, specify a rate at which annual or periodic contributions are made to an account. Benefits are not specified but are a function of the account balance, including interest, at the time of retirement.

Private pensions are provided voluntarily by employees. Nonetheless, the Congress has always required that pension trusts receiving favorable tax treatment benefit all participants without discriminating in favor of the highly paid. Pension trusts receive favorable tax treatment in three ways: (1) Employers deduct their current contributions even though they do not provide immediate compensation for employees; (2) income earned by the trust fund is tax-free; and (3) employer contributions and trust earnings are not taxable to the employee until received as a benefit. The major tax advantage, however, is the tax-free accumulation of trust interest (inside build-up) and the fact that the benefits are usually taxed at a lower rate than contributions.

In the last decade, the Congress has increasingly used special tax treatment as leverage to enforce widespread coverage and benefit receipt. In the Employee Retirement Income Security Act (ERISA) of 1974, Congress first established minimum standards for pension plans to ensure broad distribution of benefits and limited pension benefits for the highly paid. ERISA also established standards for funding and administering pension trusts, and added an employer-financed program of Federal guarantees for pension benefits promised by private employers.

In 1982, Congress sought in the Tax Equity and Fiscal Responsibility Act (TEFRA) to prevent discrimination in small corporations by requiring so-called "top heavy" plans—namely, plans in which the majority of plan assets benefit key employees—to accelerate vesting and provide a minimum benefit for short-service workers. Most of the general safeguards provided in TEFRA were later imposed on all plans in the Tax Reform Act, without repeal of the specific requirements on small businesses found in TEFRA.

In 1984, Congress enacted the Retirement Equity Act (REA) to improve the delivery of pension benefits to workers and their spouses. REA lowered minimum ages for participation to 21, provided survivor benefits to spouses of vested workers, and clarified the division of benefits in a divorce.

Title XI of the Tax Reform Act of 1986 made major changes in pension and deferred compensation plans in four general areas:

(1) limited an employer's ability to "integrate" or reduce pension benefits to account for Social Security contributions;
(2) reformed coverage, vesting, and nondiscrimination rules;
(3) changed the rules governing distribution of benefits; and
(4) modified limits on the maximum amount of benefits and contributions in tax-favored plans.

2. Issues and Congressional Response

(A) BENEFIT ADEQUACY

The objective of retirement plans is to replace workers' preretirement earnings with sufficient benefits to maintain their standard of living during retirement. In 1981, the President's Commission on Pension Policy recommended that to achieve this goal, the average wage earner would need income from pensions, Social Security, and other sources equal to approximately 75 percent of preretirement earnings. The Commission also recommended that "replacement ratios" for low-wage earners should be higher than for high-wage earners.

Because Social Security provides a higher replacement ratio to low earning workers (25 percent), pensions often tilt their benefits the other way—providing a higher replacement to the higher paid. For example, a plan for a minimum wage worker receiving 54 percent of retirement earnings from Social Security would only need to replace 20 to 35 percent of that person's preretirement earnings to meet a goal of 75 percent replacement. On the other hand, a worker paying the maximum Social Security tax (with 25 percent replacement from Social Security) would need to replace an additional 50 percent of preretirement earnings to meet that same ratio.

According to the Bureau of the Census, of all retirees receiving pension benefits in 1987, 68 percent were men. While the mean monthly pension income of male retirees was approximately $744, pension income for women was about $417 per month. The Census Bureau found that retirees under age 65 received higher pension income than those above age 65. Older retirees, however, were far more likely to be receiving Social Security benefits concurrently with their pension.

Career patterns have the greatest effect on the amount of benefits paid by pension plans. Workers who enter plans late in life or work short periods under a plan earn substantially lower benefits than those who enter early and work a full career. The Department of Labor has found that the median benefit for workers with 10 years of service under their last pension plan replaced only 6 percent of their preretirement income while the median benefit of those with 35 years of service replaced 37 percent of preretirement income. Similarly, workers who entered the plan at a young age accumulate larger pensions than those who entered the plan late in life.

(1) Coverage

In 1990, 50 million workers were covered by an employer-sponsored pension plan. Employers who offer pension plans do not have to cover each of their employees. The law governing pensions—ERISA—permits employers to exclude part-time, newly hired, and very young workers from the pension plan. In addition, the law has required employers to cover, at most, only 70 percent of the remaining workers (only 56 percent if employees must contribute to participate in the plan); and an even smaller percentage of workers if the classification of workers the plan excludes does not result in the plan discriminating in favor of the highly paid.

The 1986 Tax Reform Act increased the minimum requirements for the proportion of an employer's work force that must be covered under company pension plans. Under prior law, a plan (or several comparable plans provided by the same employer) had to meet either a "percentage test" or a "classification test" to be qualified for deferral of Federal income taxes. Employers who were unwilling to meet the straight forward percentage test found substantial latitude under the classification test to exclude large percentages of lower paid workers from participating in the pension plan. Under the percentage test, the plan(s) had to benefit 70 percent of the workers meeting minimum age and service requirements (56 percent of the workers if the plan made participation contingent upon employee contributions). A plan could avoid having to meet this test if it could show that it benefited a classification of employees that did not discriminate in favor of highly compensated employees. Classifications actually approved by the Internal Revenue Service, however, permitted employers to structure plans benefiting almost exclusively highly compensated employees.

Pension coverage was expanded in the Tax Reform Act by raising the percentage of employees that must be covered under the percentage test, and by eliminating the classification test and replacing it with much tougher and more specific alternative tests: The "ratio test" and the "average benefit test." Under the new percentage test, 70 percent of non-highly-compensated workers must benefit (as opposed to 70 percent of all workers). Alternatively, an employer can benefit a smaller percentage of the company's work force if the number of non-highly-compensated workers benefiting is at least 70 percent of the number of highly compensated workers. The average benefit test permits employers to adjust the coverage requirements to take into account the level of benefits in the plan. Employers can meet this test by providing non-highly-compensated employees, on average, at least 70 percent of the average benefit of highly compensated employees (counting noncovered employees as having zero benefits). Plans were required to meet these new coverage requirements by January 1, 1989.

Most noncovered workers, however, work for employers who do not sponsor a pension plan. Nearly three-quarters of the noncovered employees work for small employers. Small firms tend not to provide pensions because a pension plan can be administratively complex and costly. Often these firms have low profit margins and uncertain futures, and the tax benefits of a pension plan for the company are not as great for small firms.

Projected trends in future pension coverage have been hotly debated. The expansion of pension coverage has been slowing steadily over the last few decades. The most rapid growth in coverage occurred in the 1940's and 1950's when the largest employers adopted pension plans. It is unlikely that pension coverage will grow much without some added incentive for small business to add pension plans and for employers to include currently excluded workers in their plans.

(2) Vesting

Simply because a worker may be covered by a pension plan does not insure that he or she will receive retirement benefits. To receive retirement benefits, a worker must vest under the company plan. Vesting entails remaining with a firm for a requisite number of years and therefore earning the right to receive a pension.

Vesting provisions are a simple way to insure that benefits do not go to short-term workers, as well as to induce certain workers to remain on the job. Indeed, those employees who are only a few years short of vesting tend to remain on the job until they are assured of receiving a retirement benefit.

Most workers today do not stay with the same employer long enough to vest in their pension plans. ERISA standards have required that plans which vest no benefits during the first 10 years of employment fully vest those benefits after 10 years of employees service. Due to declining job tenure, today's workers are having more difficulty earning pensions than did their predecessors.

To enable more employees to either partially or fully vest in a pension plan, the 1986 Tax Reform Act required more rapid vesting than in the past. The new provisions, which applied to all employees working as of January 1, 1989, require that if no part of the benefit is vested prior to 5 years of employee service, then benefits fully vest at the end of 5 years. If a plan provides for vesting before 5 years of service, full vesting is required at the end of 7 years of service.

(3) Benefit Distribution and Deferrals

Vested workers who leave an employer before retirement usually have the right to receive vested deferred benefits from the plan when they reach retirement age. Benefits that can only be paid this way are not portable in that the departing worker may not transfer the benefits to his or her next plan or to a savings account. Many pension plans, however, allow a departing worker to take a lump-sum cash distribution of his or her accrued benefits.

Federal policy regarding lump-sum distributions has been inconsistent. On the one hand, Congress formerly encouraged the consumption of lump-sum distributions by permitting employers to make mandatory distributions without the consent of the employee on amounts of $3,500 or less; and by providing favorable tax treatment through the use of the unique "10-year forward averaging" rule (permitting the tax payment to be calculated as though the individual had no other income). On the other hand, Congress has tried to encourage departing workers to save their distributions by deferring taxes if the amount is rolled into an individual retirement account (IRA) within 60 days.

IRA rollovers, however, appear to have been largely ineffective. To the extent that workers receive lump-sum distributions, they tend to spend them rather than save them; thus distributions appear to reduce retirement income rather than increase it. Recent data indicate that only 5 percent of lump-sum distributions are saved in a retirement account and only 32 percent are retained in any form. Even among older and better educated workers, fewer than half roll their preretirement distributions into a retirement savings account.

How and when a plan distributes benefits to employees is a key factor in that plan's ability to deliver adequate retirement benefits. Even if a worker is vested, he or she may lose pension benefits under some plans upon changing jobs. This benefit loss results from differences in how some plans accrue benefits.

Final-pay formulas have been popular with employees because they relate the pension benefit to the worker's earnings immediately preceding retirement. However, final-pay plans penalize workers who leave the plan before retirement by freezing benefits at the last pay level under the plan. Workers who are years from retirement will often be entitled to pension benefits of little value. Therefore, a mobile worker earning benefits under several final-pay plans will receive much lower benefits than a steady worker who spends a full career under a single plan.

Traditionally, different types of plans have distributed their benefits in different forms. Defined-benefit pension plans have generally provided distributions only in the form of an annuity of retirement, while defined-contribution pension, profit-sharing, or thrift plans have generally provided distributions as a lump-sum payment whenever an employee leaves the company.

The Tax Reform Act of 1986 established substantial disincentives to use pension or deferred compensation plan accruals for any purpose other than providing a stream of retirement income. It imposes an excise tax of 10 percent on distributions from a qualified plan before age 59½, other than those that are taken as a life annuity, taken upon the death of the employee, upon early retirement at or after age 55, or used to pay medical expenses.

(4) Pension Integration

Current rules permitting employers to reduce pension benefits to account for Social Security benefits can result in an excessive reduction of lower paid workers' pension benefits. Under the Social Security program, employees generally pay a uniform tax rate but receive Social Security benefits that are proportionately higher at lower levels of income. Employers who want to blend their pension benefits with Social Security benefits to achieve a more uniform rate of income replacement for their retirees use integration to accomplish this goal. The integration rules define the amount of adjustment a plan can make to pension benefits before the plan is considered discriminatory.

In general, two types of integration exist—excess and offset. In excess integration, plans pay a higher contribution or benefit on earnings above a particular level (the "integration level") than they pay on earnings below that level; current rules permit plans to make no contributions below the integration level. In offset integration, plans reduce the pension benefit by a percentage of the Social Security benefit, which can result in the elimination of an individual's entire pension.

The Tax Reform Act of 1986 modified the amount of integration permissible under the revenue rulings to prevent the elimination of pension benefits. Under the new integration rules, participants receive a minimum of 50 percent of the pension benefit they would receive without integration. Defined-contribution plans cannot contribute above the wage base ($53,400 in 1991) at a rate more than twice the rate they contribute below the wage base and in no case can they have a differential greater than that under prior law (5.7 percent). Excess plans cannot pay benefits on final pay above the wage base at a rate exceeding twice the rate they pay below the wage base, nor can they have differential in the rate exceeding three-fourths of a percent times years of service. Offset plans cannot pay less than 50 percent of the pension benefit that would have been paid without integration and in no case can they reduce the pension by more than three-fourths of a percent of the participant's final average pay multiplied by years of service. The new integration rules apply to contributions or benefits that became effective January 1, 1989.

(B) TAX EQUITY

Private pensions are encouraged through tax benefits, estimated by the Treasury to be $40 billion in 1990. In return, Congress regulates private plans to prevent over-accumulation of benefits by the highly paid. Congressional efforts to prevent discriminatory provisions of benefits have focused on the potential for discrimination in voluntary savings plans and on the effectiveness of current coverage and discrimination rules.

In recent year, there has been a substantial increase in tax-free individual contributions to retirement and savings plans. Prior to 1974, only employees of public or tax-exempt organizations could elect to defer a portion of their salary without paying income taxes on it through a tax-sheltered annuity (TSA) as established under section 403(b) of the Internal Revenue Code. Private sector employees could make only after-tax contributions to a retirement plan. Beginning in 1974, the Congress gradually extended the opportunity to make tax-free elective deferrals to all employees. In 1974, Congress enacted legislation permitting workers not covered by a employer-sponsored pension plan to defer up to $2,000 a year to an IRA. Then, in 1978, they authorized cash or deferred arrangements (CODAs) for private employees under section 401(k). Workers covered under a CODA may make elective tax-free contributions (by agreeing with the employer to reduce their salaries) to an employer plan. The rules limited the amount that any worker could contribute by the total limit on all pension contributions (25 percent of salary up to $30,000) and by separate nondiscrimination tests for 401(k) plans restricting the average percentage of salary deferred by highly paid workers to 150 percent of the average percentage of salary deferred by lower paid workers. Finally, in 1981, Congress opened up the opportunity to defer $2,000 a year in an IRA to all workers.

Before 1986, concern had grown that tax-free voluntary savings offered too great a tax shelter for the highly paid and was inequitable. The tax benefits of voluntary savings are most attractive to those in the highest tax brackets. Concern grew that while a large portion of the tax benefits went to those who would probably save for retirement without it, many who need the retirement savings did not benefit from the tax provisions. In addition, there was some concern that the aggregate tax expenditures to encourage savings had become excessive. For example, the majority of those using IRAs in the past were also participating in a corporate pension or 401(k) plan.

Nondiscrimination rules are intended to ensure that employee benefit plans that are tax-favored benefit a broad cross-section of employees and not just the highly paid. Corporate pension and deferred compensation plans are required to meet a number of nondiscrimination tests for coverage and comparability of benefits as set forth in sections 401 and 410 of the Internal Revenue Code (and various revenue rulings) to become tax-qualified. Plans are required to benefit either 70 percent of the employees who meet age and service requirements (56 percent in a contributory plan) or a classification of employees that the Secretary of the Treasury finds not to be discriminatory. Benefits provided in one of a number of plans by the same employer must be reasonably comparable (in relation to pay) at various pay levels.

CODAs, in which participation is optional for the employees, must meet an additional nondiscrimination test based on the use of the plan, to ensure that the highly paid are not benefiting disproportionately from the plan.

Before 1986, there was growing concern that the coverage rules were too loosely structured and had been weakened too much through revenue rulings to ensure broad participation in employer plans by lower paid workers. In addition, there had been some concern that the CODA discrimination rules permit excessive deferrals by the highly paid in relation to the amounts actually deferred by the lower paid. Tax-sheltered annuities have not been exempt from nondiscrimination requirements for tax qualified plans since these were established under a separate section 403(b).

(1) Limitations on Tax-Favored Voluntary Savings

The Tax Reform Act of 1986 tightened the limits on voluntary tax-favored savings plans in an effort to target limited tax resources where they can be most effective in producing retirement benefits. The Act repealed the deductibility of contributions to an IRA for participants in pensions plans with adjusted gross incomes (AGIs) in excess of $35,000 (individual) or $50,000 (joint)—with a phased-out reduction in the amount deductible for those with AGIs within $10,000 below those levels. It also reduced the dollar limit on the amount employees can elect to contribute through salary reduction to an employer plan from $30,000 to $7,000 per year for private sector 401(k) plans and to $9,500 per year for public sector and nonprofit 403(b) plans. Additionally, the Act tightened the nondiscrimination test that further limits the elective contributions of highly compensated employees in relation to the actual contributions of lower paid employees. Finally, the Act encourages the small employer adoption of pension plans by permitting employers with fewer than 25 employees to adopt simplified employer pensions (SEPs) with elective employee deferrals.

(2) Limitations on Benefits and Contributions

The Internal Revenue Code limits the amount of additional accumulation an individual can have each year in a tax-favored plan. Under prior law, the annual benefits payable from a defined-benefit plan could not exceed 100 percent of an individual's compensation (up to a maximum benefit of $90,000). The annual contribution made to a defined-contribution plan could not exceed 25 percent of compensation (up to a maximum of $30,000). If an employee participates in both defined-benefit and defined-contribution plans, their total accumulation is subject to a combined limit. The dollar limits are indexed to allow cost-of-living increases.

In recent years, the Congress has reduced and frozen the section 415 limits largely in an effort to raise revenue for the Federal Government in the context of deficit reduction. The Tax Reform Act of 1986 restored the indexing of the section 415 limits, modified the relationship between the benefit and contribution amounts to establish parity, and changed the adjustment in the defined-benefit dollar limit for early retirement. The defined-benefit limit was indexed for inflation beginning in 1987, while the defined-contribution limit remained frozen until the defined-benefit limit is four times as great—a ratio of contributions to benefits that is believed to result in roughly equal retirement benefits. Once the four-to-one ratio is reached, both limits will be indexed. Although the defined-benefit limit remained the same for benefits commencing at age 65, the Tax Reform Act of 1986 required full actuarial reduction for benefits paid at earlier ages—so that the maximum annual benefit for someone retiring at age 55 is reduced from the current floor of $75,000 to $40,000.

To reduce the potential for an individual to overaccumulate by using several plans, the Tax Reform Act of 1986 both retained the current law combined limit and added a 15-percent excise tax to recapture the tax benefits of annual benefits (including IRA withdrawals) in excess of 125 percent of the defined-benefit limit (but not less than $150,000).

One of the major purposes of the retirement provisions of the Tax Reform Act of 1986 was to expand the proportion of the population receiving pension benefits and raise average benefits from employer-sponsored plans. Data prepared by ICF, Inc. for the American Association of Retired Persons (AARP) indicates that the combination of expanded coverage, 5-year vesting, limits on pension integration, and tighter distribution rules is expected to substantially increase future benefits paid to today's younger workers. The study simulated the pension income received by the families of workers who will reach age 67 in the years 2011–20. The benefit improvements in the Tax Reform Act will raise average annual family pension income from $8,400 (under prior law) to $10,200 (1986 dollars) and will increase the percentage of families receiving pension income from 68 percent (under prior law) to 77 percent. Women, in particular, are expected to benefit from the pension reforms. ICA estimated that the Tax Reform Act of 1986 changes will increase the number of women with pension benefits during the 2011–20 period by 23 percent.

(C) PENSION FUNDING

The contributions plan sponsors set-aside in pension trusts are invested to build sufficient assets to pay benefits to workers throughout their retirement. The Federal Government, through the Employee Retirement Income Security Act of 1974 (ERISA), regulates the level of funding and the management and investment of pension trusts. Under ERISA, plans that promise a specified level of benefits (defined-benefit plans) must either have assets adequate to meet benefit obligations earned to date under the plan or must make additional annual contributions to reach full funding in the future. Plans predating ERISA are allowed 40 years to full-funding. Under ERISA, all pension plans are required to diversify their assets, are prohibited from buying, selling, exchanging, or leasing property with a "party-in-interest," and prohibited from using the assets or income of the trust for any purpose other than the payment of benefits or reasonable administrative costs.

Prior to ERISA, participants in underfunded pension plans lost their benefits when employers went out of business. To correct this problem, ERISA established a program of termination insurance to guarantee the vested benefits of participants in single-employer defined-benefit plans. This program guaranteed benefits up to $1,858 a month in 1987 (adjusted annually). The single-employer program is funded through annual premiums paid by employers to a nonprofit Government corporation—the PBGC. When an employer terminated a plan, the PBGC received any assets up to 30 percent of the employer's net worth. A similar termination insurance program was enacted in 1980 for multiemployer defined-benefit plans, using a slightly higher annual premium, but guaranteeing only a portion of the participant's benefits.

(1) Termination of Underfunded Plans

The past years have brought increasing concern that the single-employer termination insurance program, operated by the PBGC, is inadequately funded. A major cause of the PBGC's problem has been the ease with which economically viable companies could terminate underfunded plans and dump their pension liabilities on the termination insurance program. Employers unable to make required contributions to the pension plan requested funding waivers from the IRS, permitting them to withhold their contributions, and thus increase their unfunded liabilities. As the underfunding grew, the company terminated the plan and transferred the liability to the PBGC. The PBGC was helpless to prevent the termination and was also limited in the amount of assets that it could collect from the company to help pay for underfunding to 30 percent of the company's net worth. PBGC was unable to collect much from the financially troubled companies since they were likely to have little or no net worth.

Terminations of underfunded pension plans have also reduced the benefits paid to participants and beneficiaries. Even though vested benefits are generally insured by the PBGC, the termination insurance program does not protect all benefits vested in underfunded plans. Employees are often in a difficult position when an employer terminates an underfunded plan. On the one hand, the inability of the company to restructure its debt may force the company to go out of business and the workers to lose their jobs.

While during the past few years, the PBGC has assumed responsibility for several large claims, none was as large as that of the LTV Corporation, which filed for Chapter 11 bankruptcy in 1986. LTV's three terminated steel pension plans doubled PBGC's deficit from $2 billion to $4 billion and illustrated a fundamental weakness of the termination insurance program. Under the law, companies such as LTV could eventually become profitable, in part because they had succeeded in dumping pension liabilities on the PBGC. The result was that participants in the pension plans of such companies (through some loss in benefits) and the companies' competitors (through higher premiums to the PBGC) were subsidizing their future profitability. The Supreme Court decided in 1990 that the PBGC did have the authority to restore LTV's pension obligations back to the corporation.

During 1986, several important events took place with regard to pension underfunding. First, the premium paid to the PBGC by employers was increased per participant. In addition, the circumstances under which employers can terminate underfunded pension plans and dump them into the PBGC's lap were tightened up considerably. A distinction is now made between "standard" terminations, where the employer is unlikely to have adequate assets to meet plan obligations. In a standard termination, employers will have to pay all benefits commitments under the plan, including benefits in excess of the amounts guaranteed by the PBGC that were vested prior to termination of the plan. A distress termination—where a company has filed for bankruptcy, or will clearly go out of business unless the plan was terminated, or where the cost of the pension has become unreasonably burdensome—involves increased employer liability to both the PBGC and plan participants.

While significant accomplishments were made in 1986, however, the new changes did not solve the PBGC's financing problems. The insurance agency's troubles grew substantially worse with the termination of the pension plans of the bankrupt LTV Corporation at the end of 1986 and beginning of 1987. As a remedy, a provision in the OBRA 1987, called for an additional PBGC premium increase as of 1989. Beginning in 1989, firms were required to pay a premium ranging from $16 to $50 per employee. This "variable-rate premium" forces those companies with large unfunded liabilities to pay more. While the companies sponsoring the 83 percent of all pension plans which are adequately funded were only required to pay $16 per employee, companies sponsoring the remaining 17 percent were forced to pay a variable premium, according to their level of underfunding. The law required companies to pay an additional $6 per employee for each $1,000 of underfunding. According to the PBGC, roughly 4 percent of all plans paid the maximum rate of $50 per employee. Companies were also required to make quarterly payments to the PBGC, rather than annual payments as had been the case. Due to the difficult conditions presently existing in the steel industry, the new provisions gave steel companies a 5-year transition period.

The variable-rate premium resulted from lengthy debate. The administration had proposed a variable-rate premium ranging from $8.50 to $100 per employee. Unions bitterly opposed the administration proposal, stating that it would deepen the crises of companies which were already financially troubled. Therefore, the unions favored a Democratic alternative calling for a $20 flat-rate premium. However, this idea was unacceptable to the business community. In the end, the above-mentioned compromise was enacted into law.

In the OBRA 1990, Congress increased the flat premium rate to $19 a participant. Additionally, it increased the variable rate to $9 per $1,000 of unfunded vested benefits. Also, the Act increased the per participant cap on the additional premium to $53.

Concerned about terminations of overfunded plans, Congress changed the tax rules governing terminations in 1990. The OBRA 1990 increased the excise tax on reversions from 20 percent to 50 percent depending on certain circumstances. The excise rate is 20 percent if the employer sets up a replacement plan and leaves a "cushion" equal to 25 percent of the surplus, or gives cash payments equaling 20 percent of the surplus to retirees and workers. The excise tax is 50 percent if the company does not maintain a qualified replacement plan.

On a temporary basis, qualified transfers of excess plans may be transferred to a section 401(h) retiree health plan. The assets transferred are not included in the gross income of the employer and are not subjected to the excise tax on reversions.

(D) PENSION ACCRUAL

A provision in the OBRA 1986 required that the IRS, the Equal Employment Opportunity Commission (EEOC), and the Department of Labor issue regulations requiring employers to continue accruing pension benefits for employees working beyond normal retirement age by early 1988. The IRS, followed by the EEOC and the Department of Labor, were required to develop regulations in accordance with the new law.

In April 1988, the IRS proposed a rule providing that in defined-benefit plans all years of service be taken into account in determining retirement benefits. In contrast, with respect to defined-contribution plans, the law would not be applied retroactively under the IRS ruling. Under the rule, a worker with a defined-benefit plan and who turns age 65 prior to 1988 would accrue pension credits for years of service prior to the law's 1988 effective date. However, if the same worker were covered by a defined-contribution plan, only employment after January 1988 would be credited.

3. Prognosis

While the financial picture of the PBGC continues to be of concern, other issues such as inadequate pension coverage and simplification of pension regulations promise to receive a great deal of attention in the near future.

The issue of pension portability also promises to receive some attention. Pension benefit portability involves the ability to maintain an employee's benefits upon a change in employment. Proponents argue that the mobility of today's work force demands benefit portability. Alternatives to expand pension portability that will likely receive attention during 1991 include proposals to establish a Federal portability agency or a central clearinghouse, which would maintain accounts on behalf of workers, and proposals to expand the current retirement arrangements to require or facilitate rollovers of preretirement distributions to an employer plan or an IRA.

B. STATE AND LOCAL PUBLIC EMPLOYEE PENSION PLANS

1. Background

State and local government pension plans cover 11.4 million active and 3.1 million retired participants in more than 6,600 plans. In 1989, State and local pension plans has assets of $727.4 billion. More than 80 percent of these plans have fewer than 100 active members each. About 95 percent of active memberships are included in the largest 6 percent of plans. Nearly three-quarters of the State and local plans provide coverage under Social Security, but most do not integrate Social Security and pension benefits.

State and local pension plans intentionally were left outside the scope of Federal regulations under ERISA in 1974, even though there was concern at the time about large unfunded liabilities and the need for greater protection for participants. Although unions representing State and municipal employees from the beginning have supported the application of ERISA-like standards to these plans, opposition, from local officials and interest groups thus far have successfully counteracted these efforts, arguing that the extension of such standards would be an unwarranted and unconstitutional interference with the right of State and local governments to set the terms and condition of employment for their workers.

(A) TAX REFORM ACT OF 1986

Public employee retirement plans were affected directly by several provisions of the Tax Reform Act of 1986. The Act made two changes that apply specifically to public plans: (1) The maximum employee elective contributions to voluntary savings plans (401(k), 403(b), and 457 plans) were substantially reduced, and (2) the once-favorable tax treatment of distributions from contributory pension plans was eliminated.

(B) ELECTIVE DEFERRALS

The Tax Reform Act of 1986 set lower limits for employee elective deferrals to savings vehicles, coordinated the limits for contributions to multiple plans, and prevented State and local governments from establishing new 401(k) plans. The maximum contribution permitted to an existing 401(k) plan was reduced from $30,000 to $7,000 a year and the nondiscrimination rule that limits the average contribution of highly compensated employees to a ratio of the average contribution of employees who do not earn as much was tightened. The maximum contribution to a 403(b) plan (tax-sheltered annuity for public school employees) was reduced to $9,500 a year and employer contributions for the first time were made subject to nondiscrimination rules. In addition, preretirement withdrawals were restricted unless due to hardship. The maximum contribution to a 457 plan (unfunded deferred compensation plan for a State or local government) remained at $7,500, but is coordinated with contributions to a 401(k) or 403(b) plan. In addition, 457 plans were required to commence distributions under uniform rules that apply to all pension plans. The lower limits were effective for deferrals made on or after January 1, 1987, while the other changes generally were effective January 1, 1989.

(C) TAXATION OF DISTRIBUTIONS

The tax treatment of distributions from public employee pension plans also was modified by the Tax Reform Act of 1986 to develop consistent treatment for employees in contributory and noncontributory pension plans. Before 1986, public employees who had made after-tax contributions to their pension plans could receive their own contributions first (tax-free) after the annuity starting date if the entire contribution could be recovered within 3 years, and then pay taxes on the full amount of the annuity. Alternately, employees could receive annuities in which the portions of noticeable contributions and taxable pensions were fixed over time. The Tax Reform Act repealed the 3-year basis recovery rule that permitted tax-free portions of the retirement annuity to be paid first. Under the new law, retirees from public plans must receive annuities that are a combination of taxable and nontaxable amounts.

The tax treatment of preretirement distributions was changed for all retirement plans in an effort to discourage the use of retirement money for purposes other than retirement. A 10-percent penalty tax applies under the new law to any distribution before age

59½ other than distributions in the form of a life annuity: At early retirement at or after age 55; in the event of the death of the employee; or in the event of medical hardship. In addition, refunds of after-tax employee contributions, and payments from 457 plans are not subject to the 10-percent penalty tax. The new tax law also repealed the use of the advantageous 10-year forward-averaging tax treatment for lump-sum distributions received prior to age 59½, and provides for a one-time use of 5-year forward-averaging after age 59½.

The Tax Reform Act of 1986 also made a number of changes that apply to tax-qualified pension plans, but do not apply directly to government plans. These include a reduction in the vesting period from 10 years to 5 years, modifications in the rules for integration of pension and Social Security benefits to require payment of at least half of a nonintegrated pension benefit, tighter pension coverage, and nondiscrimination rules to encourage broader participation in pension plans by lower paid employees.

2. ISSUES AND CONGRESSIONAL RESPONSE

(A) FEDERAL REGULATION

Issues surrounding Federal regulation of public pension plans have changed little in the past 10 years. A 1978 report to Congress by the Pension Task Force on Public Employee Retirement Systems concluded that State and local plans often were deficient in funding, disclosure, and benefit adequacy. The Task Force reported many deficiencies that still exist, including:

> Government retirement plans, particularly smaller plans, frequently were operated without regard for generally accepted financial and accounting procedures applicable to private plans and other financial enterprises. There was a general lack of consistent standards of conduct.
>
> Open opportunities existed for conflict-of-interest transactions, and frequent poor plan investment performance.
>
> Many plans were not funded on the basis of sound actuarial principles and assumptions, resulting in adequate funding that could place future beneficiaries at risk of losing benefits altogether.
>
> There was a lack of standardized and effective disclosure, creating a significant potential for abuse due to the lack of independent and external reviews of plan operations.
>
> Although most plans effectively met ERISA minimum participation and benefit accrual standards, two of every three plans, covering 20 percent of plan participants, did not meet ERISA's minimum vesting standard.

There remains considerable variation and uncertainty in the interpretation and application of provisions pertaining to State and local retirement plans, including the antidiscrimination and tax qualification requirements of the Internal Revenue Code. While most administrators seem to follow the broad outlines of ERISA benefit standards, they are not required to do so. Recent studies suggest that the growth rate of public funds is outstripping the growth of private plans as public fund administrators move aggressively to fund unfunded liabilities. The sheer size of the investment funds suggests that a Federal standard might be prudent.

However, the need for improved standards has not obscured the latent constitutional question posed by Federal Regulation. In *National League of Cities* v. *Usery,* the U.S. Supreme Court held that extension of Federal wage and maximum hour standards to State and local employees was an unconstitutional interference with State sovereignty reserved under the 10th amendment. State and local governments have argued that any extension of ERISA standards would be subject to court challenge on similar grounds. However, the Supreme Court's decision in 1985 in *Garcia* v. *San Antonio Metropolitan Transit Authority* overruling *National League of Cities* largely has resolved this issue in favor of Federal regulation.

Perhaps in part because of the lingering question of constitutionality, the focus of Congress has been fixed on regulation of public pension with respect to financial disclosure only. Some experts have testified that much of what is wrong with State and local pension plans could be improved by greater disclosure.

A definitive statement on financial disclosure standards for public plans was issued in 1986 by the Government Accounting Standards Board (GASB). Statement No. 5 on "Disclosure of Pension Information by Public Employee Retirement Systems and State and Local Governmental Employers" established standards for disclosure of pension information by public employers and public employee retirement systems (PERS) in notes in financial statements and in required supplementary information. The disclosures are intended to provide information needed to assess the funding status of PERS, the progress made in accumulating sufficient assets to pay benefits, and the extent to which the employer is making actuarially determined contributions. In addition, the statement requires the computation and disclosure of a standardized measure of the pension benefit obligation. The statement further suggests that 10-year trends on assets, unfunded obligations, and revenues be presented as supplementary information.

3. Prognosis

Some observers have suggested that the sheer size of the public fund asset pool will lead to its inevitable regulation. Critics of this position generally believe that the diversity of plan design and regulation is necessary to meet divergent priorities of different localities and is the strength, not weakness, of what is collectively referred to as the State and local pension system. While State and local governments consistently oppose Federal action, increased pressures to improve investment performance, coupled with the call for responsible social investment, may lessen some of the opposition of State and local plan administrators to some degree of Federal regulation. However, the need to focus on problems with private pensions may delay congressional attention to public pension issues.

C. FEDERAL CIVILIAN EMPLOYEE RETIREMENT

1. BACKGROUND

From 1920 until January 1, 1987, the Civil Service Retirement System (CSRS) was the retirement plan for all Federal civilian employees. That was changed with the enactment of legislation creating the Federal Employees Retirement System (FERS). CSRS covers all employees hired before January 1, 1984, who did not transfer to FERS by December 31, 1987. CSRS will cease to exist when the last employee in the system dies. FERS covers all Federal employees hired on or after January 1, 1984.

A key difference in the plans is that the FERS benefit includes Social Security. Enactment of the Social Security Amendments of 1983 implemented a recommendation of the 1981 National Commission on Social Security Reform and mandated Social Security coverage for all Federal employees hired on or after January 1, 1984. Social Security coverage of Federal employees compelled the Congress to review the retirement benefits for such employees and examine various retirement options. The Social Security coverage duplicated some CSRS benefits and would have increased combined employee contributions to more than 13 percent. Therefore, with Public Law 98-168 in 1983, Congress established an interim arrangement, pending the enactment of a permanent new plan. After extended debate, the Federal Employees' Retirement System Act of 1986 (P.L. 99-335) was approved in 1986.

(A) CIVIL SERVICE RETIREMENT SYSTEM

CSRS is the largest pension plan in the country, a pay-as-you-go system financed roughly one-fifth from employees' payroll taxes, one-fifth from the employing agency, with the balance coming from Federal general revenues. CSRS participants contribute 7 percent of total basic pay and do not pay the Social Security tax.

The annual cost of the retirement system increased from $2.5 billion in 1970 to a total of $31.1 billion in fiscal year 1990 ($30.9 billion for CSRS; $217.1 million for FERS). The number of annuitants grew from 962,000 to an estimated 2.2 million during this same period. During the 1970-90 period, CSRS retirement benefits increased 226 percent, military retirement benefits 226 percent, and Social Security benefits 264 percent. During the same period, the Consumer Price Index (CPI) increased 239 percent.

The CSRS benefits structure is as follows: After 5 years of service, vested benefits equal a percentage of the highest 3 years of pay. Unreduced benefits are payable at age 55 with at least 30 years of service; age 60 with at least 20 years of service; and age 62 with at least 5 years of service. Employees receive credit for unused sick leave if they continue to work until retirement. Payment of benefits for those who leave Federal service before they are eligible for retirement cannot start before age 62. Employees have the right to withdraw their own contributions without interest and forfeit all CSRS benefits. CSRS also provides disability and survivors benefits.

The OBRA 1986 protects CSRS cost-of-living adjustments (COLAs) from sequestration under the Gramm-Rudman-Hollings

Act. However, Congress can still mandate reductions of cancellations of the COLAs to meet budget deficit reduction targets. On January 1, 1991, a COLA of 5.4 percent was provided to retirees under CSRS.

Since 1987, a Thrift Savings Plan (TSP) option has been available to CSRS participants which allows an employee to invest up to 5 percent of pay in a tax-deferred plan. The OBRA 1987, exempts the TSP from antidiscrimination rules which apply to similar tax-deferred plans in the private sector. Therefore, all CSRS participants may contribute to TSP and will not face possible reduction of the allowable contribution rate, no matter what their income level. The Government makes no matching contribution to the TSP for CSRS employees.

(B) THE FEDERAL EMPLOYEES RETIREMENT SYSTEM

(1) Social Security Plus a Basic Defined-Benefit Plan

The FERS plan is comprised of three tiers: a defined-benefit plan, Social Security, and a Thrift Savings Plan. The FERS benefit plan is similar to private-sector plans in many respects and allows workers to earn 1 percent of the average of their highest 3 consecutive years of wages for each year of service completed. Workers retiring at age 62 or later with at least 20 years of service will receive an additional 0.1 percent of pay for each year of service. Unlike CSRS, unused sick leave cannot be used for computation of retirement benefits.

In contrast to CSRS, the FERS benefit is reduced if an employee retires before age 62. Unreduced benefits from FERS will be payable at age 62 with 5 years of service, at age 60 with 20 years of service, and at the minimum retirement age (MRA) with 30 years of service. Workers who leave Federal service involuntarily at any age with at least 25 years of service, or after age 50 with at least 20 years of service, will be eligible for unreduced benefits.

The MRA is 55 for workers who reach that age by the year 2002, and increases 2 months per year, reaching age 56 in 2009. Beginning in 2021, the MRA again rises by 2 months per year until the full retirement age (57) is reached in 2027. Reduced benefits are payable to retiring employees over the MRA with 10 years of service. The reduction is 5 percent for each year under age 62.

Retirees with unreduced benefits between the MRA and age 62 will be paid a supplement approximately equal to the amount of the estimated Social Security benefit based on Federal service payable to the retiree at age 62. This supplement also will be paid to involuntarily separated workers from ages 55 to 62. Supplemental payments will be subject to an earnings test similar to that for Social Security beneficiaries.

Deferred benefits will be payable at age 62 to workers who leave Federal service before retirement, provided they have at least 5 years of service and have not withdrawn their contributions. Deferred benefits also are payable without reduction to workers at the MRA with 30 years of service at separation or at age 60 with 20 years of service at separation. Reduced deferred benefits also are available at age 55 with at least 10 years of service. The reduction is 5 percent for each year under 62.

COLAs will be paid annually based on changes in prices as measured by the CPI for retirees over age 62. The COLA will match the CPI increase up to 2 percent. If the CPI increase exceeds 2 percent, the COLA will be the greater of 2 percent or the CPI increase minus 1 percent. On January 1, 1991, a COLA of 4.4 percent was provided to FERS retirees.

(2) Employee Contributions

Unlike CSRS participants, employees participating in FERS are required to contribute to Social Security. The tax rate for Social Security coverage was 5.7 percent of pay in 1986 and 1987, 6.06 percent in 1988, and 6.2 percent in 1990 and 1991 up to the taxable wage ceiling ($53,400 in 1991). The wage ceiling is indexed to the annual growth of wages in the national economy. In FERS, employees contribute the difference between 7 percent of basic pay and the Social Security tax rate.

At separation from service, employees have the option of withdrawing their contributions to FERS. This means the employee relinquishes the employer's contribution. An employee separating after 1 year of service will receive interest on their contributions. An important difference between CSRS and FERS is that FERS employees who withdraw their contributions will *not* be able to redeposit money in order to recapture credit for that service.

(3) Disability Benefits

After 18 months of creditable service, employees are eligible for disability retirement if they are unable, because of disease or injury, to perform useful and efficient services in their current position or a vacant position at the same grade level in the same agency and commuting area. Employees applying for disability benefits under FERS may also apply for disability benefits under the Social Security system. Benefits will be based on the 3 highest years of pay and be offset, to an extent, by Social Security benefits.

(4) Survivor Benefits

The FERS survivor benefit provides lump sum payments to surviving spouses of workers who die before retirement, as well as annuities for the survivors in certain areas. Survivors of retired workers are eligible for an annuity if the couple has elected the survivor annuity plan. The survivor annuity plan may be waived only if the spouse provides written, notarized consent.

Children's survivor benefits under FERS are payable to surviving children until age 18, or until 21 if they are full-time students. Disabled children incapable of self-support may continue to receive benefits for life if the disability began prior to age 18. All children's benefits are offset by any Social Security benefits for which they are eligible.

(5) Thrift Savings Plan

FERS supplements the defined-benefits plan and Social Security with a contribution plan that is similar to the 401(k) plans used by private employers. Employees accumulate assets in the TSP in the form of a savings account that either can be withdrawn in a lump sum or converted to an annuity when the employee retires. One percent of pay is automatically contributed to the TSP by the employing agency. Employees can contribute up to 10 percent of their salaries to the TSP. The employing agency will match the first 3 percent of pay contributed on a dollar-for-dollar basis and match the next 2 percent of pay contributed at the rate of 50 cents per dollar. The maximum matching contribution to the TSP by the Federal agency will equal 4 percent of pay plus the 1 percent automatic contribution. Therefore, employees contributing 5 percent or more of pay will receive the maximum employer match. An open season is held every 6 months to permit employees to change levels of contributions and direction of investments. Employees are allowed to borrow from their accumulated TSP for the purchase of a primary residence, educational or medical expenses, or financial hardship.

FERS originally contained restrictions on optional investment opportunities, such as fixed-income securities or a stock index fund, phasing-in the funds over a 10-year period. Public Law 101-335 eliminated the 10-year phase-in period for FERS TSP participants and for the first time allowed CSRS TSP participants to invest in these funds. The legislation also exempted TSP annuities from State and local premium taxes, as was done for the Federal Employees Group Life Insurance program in 1981.

2. Issues and Congressional Response

A. LUMP SUM WITHDRAWAL OF CONTRIBUTIONS

The law creating FERS contained a provision allowing those retiring under CSRS or FERS to withdraw at the time of their retirement their contributions to the system in exchange for a reduction in their annuity to reflect the withdrawn sum. The pension is then actuarially reduced so that over the retiree's lifetime the amount received as a monthly payment plus the withdrawal would be the same amount which would have been received if the withdrawal has not been made.

The OBRA 1990, suspended the lump sum annuity option for 5 years, beginning December 1, 1990. Employees retiring before November 30, 1990, will receive the lump sum in two payments of 50 percent each. However, the Act did create exceptions which will allow certain individuals to elect the lump sum annuity option during the 5-year suspension. The exceptions are as follows:

—employees who are terminally ill and meet the age and service requirements for voluntary retirement may elect the lump sum in a 100 percent payment;

—employees who are involuntarily separated for reasons other than misconduct or delinquency and who meet the age and service requirements for voluntary retirement may elect the lump sum in two payments of 50 percent each; this category does not include Members of Congress, Schedule C appointees, or noncareer members of the Senior Executive Service; and

—employees who are employed in direct support of Operation Desert Shield and who are eligible for retirement before

December 1, 1990, may retire before December 1, 1991, and elect the lump sum in two payments of 50 percent each.

The legislation also precludes the distribution of the two lump sum payments in 1 year to avoid harsh tax consequences.

(B) SOCIAL SECURITY PUBLIC PENSION OFFSET

Social Security benefits payable to spouses of retired, disabled, or deceased workers generally are reduced to take into account any public pension the spouse receives from government work not covered by Social Security. The amount of the reduction equals two-thirds of the government pension. In other words, $2 of the Social Security benefits is reduced for every $3 of pension income received. Workers with at least 5 years of FERS coverage are not subject to the offset.

According to a 1988 GAO report entitled: *Federal Workforce—Effects of Public Pension Offset on Social Security Benefits of Federal Retirees,* 95 percent of Federal retirees had their Social Security spousal or survivor benefits totally eliminated by the offset.

(C) SOCIAL SECURITY WINDFALL BENEFIT REDUCTION

Workers who have less than 30 years of Social Security coverage and a pension from non-Social Security covered employment are subject to the windfall penalty formula when their Social Security benefit is computed. The windfall penalty was enacted as part of the Social Security Amendments of 1983 in order to reduce the disproportionately high benefits "windfall" that such workers would otherwise receive from Social Security. Because the Social Security benefits formula is weighted, low-income workers and workers with fewer years of covered service receive a higher rate of return on their contributions than high income workers who are more likely to also have private pension income. However, the formula did not distinguish between workers with low-income earnings and workers with fewer years of covered service which resulted in a windfall to the latter group. To eliminate this windfall, Congress adopted the windfall benefit formula and then modified the formula before it was fully phased-in.

Under the regular Social Security benefit formula, the basic benefit is determined by applying three factors (90 percent, 32 percent, and 15 percent) to three different brackets of a person's average indexed monthly earnings (AIME). These dollar amounts increase each year to reflect the increase in wages. The formula for a worker who turns 62 in 1991 is 90 percent of the first $370 in average monthly earnings, plus 32 percent of the amount between $370 and $2,230, and 15 percent of the amount over $2,230.

Under the original 1983 windfall benefit formula, the first factor in the formula was 40 percent rather than 90 percent with the 32 percent and 15 percent factors remaining the same. With the passage of the Technical Corrections and Miscellaneous Revenue Act of 1988, Congress modified the windfall reduction formula and created the following schedule:

Years of Social Security Coverage:	*First Factor in Formula Percent*
20 or fewer	40
21	45
22	50
23	55
24	60
25	65
26	70
27	75
28	80
29	85
30 or more	90

Under the windfall benefit provision, the windfall formula will reduce the Social Security benefit by no more than 50 percent of the pension resulting from noncovered service.

(D) TAXATION OF LUMP SUM PAYMENTS AT RETIREMENT

The Tax Reform Act of 1986 treats post-retirement lump sum payments of employee contributions the same as full annuity payments. That is, the value of the lump sum payment and the remaining annuity amount are combined and the proportionate shares of the employer's and employee's contributions are assessed. This rate is then applied to both the monthly annuity payments and the total lump sum payment.

The law places a penalty on the withdrawal of an employee's contributions in certain limited circumstances. The 10 percent penalty on early withdrawals from Individual Retirement Accounts (IRAs), except in cases of hardship, is extended to early withdrawals from qualified pension plans. This penalty affects Federal workers under age 55 who retire under early retirement provisions pertaining to job abolishments, reorganizations, reductions-in-force, or job categories which allow retirement at age 50 with 20 years of service. The withdrawal usually cannot be rolled over into an IRA or other qualified plan because it generally will constitute 50 percent of the employee's lifetime annuity and therefore will not meet the IRS requirement for rollovers.

3. PROGNOSIS

Congress is unlikely to make major changes in either CSRS or FERS in the foreseeable future. Some minor changes may be made in the TSP to address unforeseen administrative needs of a large investment plan.

D. MILITARY RETIREMENT

1. BACKGROUND

For more than four decades following the establishment of the military retirement system at the end of World War II, the retirement system for servicemen remained virtually unchanged. However, the enactment of the Military Retirement Reform Act of 1986 (P.L. 99-348), brought major reforms to the system. The Act affected the future benefits of servicemembers first entering the military on or after August 1, 1986. Because a participant only becomes vested in the military retirement program after 20 years of service, the first retirees affected by the new law will be those with 20 years of service retiring on August 1, 2006.

In 1987, 1.6 million retirees and survivors received military retirement benefits. For fiscal year 1988, total Federal military retirement outlays have been estimated at $18.9 billion. Three types of benefits are provided under the system: Standard retirement benefits, disability retirement benefits, and survivor benefits under the Survivor Benefit Program (SBP). With the exception of the SBP, all benefits are paid by contributions from the employing branch of the armed service, without contributions by the participants.

Servicemembers who retire from active duty receive monthly payments based on a percentage of their retired pay computation base. For persons who entered military service before September 8, 1980, the computation base is the final monthly base pay being received at the time of retirement. For those who entered service on or after September 8, 1980, the retired pay computation base is the average of the highest 3 years of base pay. Base pay comprises approximately 65–70 percent of total pay and allowances.

Retirement benefits are computed using a percentage of the retired pay computation base. The retirement benefit for someone entering military service prior to August 1, 1986, is determined by multiplying the years of service by a multiple of 2.5. Under this formula, the minimum amount of retired pay to which a retiree is entitled after a minimum of 20 years of service is 50 percent of base pay. A 25-year retiree receives 62.5 percent of base pay, with a 30-year retiree receiving the maximum—75 percent of base pay.

The Military Retirement Reform Act of 1986 changed the computation formula for military personnel who enter military service on or before August 1, 1986. For retirees under age 62, retired pay will be computed at the rate of 2 percent of the retired pay computation base for each year of service through 20, and 3.5 percent for each year of service from 21 through 30. Under the new formula, a 20-year retiree under age 62 will receive 40 percent of his or her basic pay, 57.5 percent after 25 years, and 75 percent after 30 years. Upon reaching 62, however, all retirees have their benefits recomputed using the old formula. The changed formula, therefore, favors the longer serving military careerist, providing an incentive to remain on active duty longer before retiring. Since most military personnel retire after 20 years, the cut from 2.5 percent to 2 percent will cut program costs. These changes in the retired pay computation formula applies only to active pay nondisability retirees. Disability retirees and Reserve retirees are not affected.

Benefits are payable immediately upon retirement from military service, regardless of age, and without taking into account other sources of income, including Social Security. By statute, all benefits are fully indexed for changes in the (CPI). In the event of an across-the-board budget cut under Gramm-Rudman-Hollings, military retirement COLAs are exempt from sequestration. Under the Military Retirement Reform Act of 1986, however, COLAs will be held at 1 percentage point below the CPI for military personnel beginning their service after August 1, 1986.

2. ISSUES AND CONGRESSIONAL RESPONSE

(A) COST

The military retirement system repeatedly has been criticized for providing lavish benefits and being too expensive. The Military Retirement Reform Act of 1986 was enacted in response to these criticisms. The Act's purpose was to contain the costs of the military retirement system and provide incentives for experienced military personnel to remain on active duty.

Approximately 1.5 million retired officers, enlisted personnel, and their survivors received nearly $18.9 billion in annuity payments in 1987. At the current rate of growth, this expenditure will reach an estimated $45 billion annually by the year 2000. In 1986, military retirees received an average of $12,671 in annuities.

Four features of the military retirement system contribute to its cost:

(1) Full benefits begin immediately upon retirement; the average retiring enlisted member begins drawing benefits at 42, the average officer at 46. Benefits continue until the death of the participant.

(2) Military retirement benefits are indexed for inflation.

(3) The system is basically noncontributory, although in order to provide survivor protection, the participant must make some contribution.

(4) Military retirement benefits are not integrated with Social Security benefits.

Supporters of the current military retirement scheme have identified several characteristics unique to military life that justify relatively more liberal benefits to military retirees than other Federal retirees:

(1) All retired personnel are subject to involuntary recall in the event of a national emergency; retirement pay is considered part compensation for this exigency.

(2) Military service places different demands on military personnel than civilian employment, including higher levels of stress and danger and more frequent separation from family.

(3) The benefit structure has provided a significant incentive for older personnel to leave the service and maintain "youth and vigor" in the armed services. In this respect, it has been largely successful. Almost 90 percent of military retirees are under age 65, 50 percent under the age of 50.

Military personnel do not contribute to their retirement benefits, though they do pay Social Security taxes and offset a certain amount of their pay to participate in the survivor benefit program. Very few of the studies conducted in the past decade have recommended contributions by individuals. As a result, no refunds of contributions are available to those leaving the military before the end of 20 years. The full cost of the program appears as an agency expense in the budget; under the civilian retirement system four-fifths of the retired plans costs appear in the agency budgets.

Since the beginning of Social Security coverage for military personnel in 1945, military retirement benefits have been paid without any offset for Social Security. Taking into account the frequency with which military personnel in their mid-forties retire after 20 years of service, it is not unusual to find them retiring from a second career with a pension from their private employment along with their military retirement and a full Social Security benefit. Lack of integration of military retirement and Social Security benefits may add to the perception that military retirement benefits are overly generous.

Military retirement is fully indexed for inflation, as are Social Security and the Civil Service Retirement System, a feature that retirees traditionally have considered central to the adequacy of retirement benefits. In recent years, full indexing of military and other Federal retirement benefits was the object of the administration's deficit-reduction measures. As a result of the original provisions of the Gramm-Rudman-Hollings Act, the 1986 military retiree COLA was cancelled. Since that time, however, legislation was enacted that excluded the COLA from sequestration.

(B) RETIREMENT ADEQUACY

The pivotal issues in evaluating the military retirement system, however, is not cost, but the system's ability to provide adequate retirement income to those men and women who serve in the armed services. Several recent studies of the military retirement system have suggested that the 20-year service requirement is unfair to the majority of military personnel. Nearly 65 percent of officers and 90 percent of enlisted personnel leave before completing the requisite 20 years of service. It has been suggested that this design is likely to prolong the careers of marginal military personnel beyond their usefulness, while simultaneously providing an incentive for highly skilled and experienced personnel to leave the armed services for second careers as soon as they complete 20 years of service, in order to capitalize on private sector employment opportunities and pensions. The result is a system that pays relatively high benefits to a disproportionately high number of officers when compared to the composition of the military as a whole.

Commentators periodically have called for shorter vesting schedules, comparable to those required for private plans under ERISA or for the Federal service jobs. Some military manpower experts have argued that such a change would adversely impact the ability to maintain a vigorous and youthful military force. On the other hand, some military manpower analysts argue that the need for youth and vigor is overstated in view of new technologies that put a premium on technical skills rather than physical endurance.

(C) THE MILITARY SURVIVOR BENEFIT PLAN

The Military Survivor Benefit Plan (SBP) was created in 1972 by Public Law 92–425. Under the plan, a military retiree can have a portion of his or her retired pay withheld to provide a survivor annuity to a spouse, spouse and child, child only, person with an "insurable interest," or a former spouse. As a result of the SBP, a military retiree can provide for an annuity of up to 55 percent of his or her total retired pay at the time of death to be paid to a surviving spouse. Upon reaching age 62, the SBP annuity automatically is reduced to 35 percent of military retired pay for all surviving spouses. This offset occurs regardless of whether the survivor is eligible for Social Security retirement or survivors benefits and regardless of any other sources of income available to the surviving spouse.

A retiree automatically is enrolled in the plan upon retirement at the maximum rate unless he or she chooses, in writing, not to participate or to do so at a lesser level of protection. If such a choice is made, the spouse must be notified. SBP annuities are adjusted for the cost-of-living on the same basis as military retired pay. No coverage reductions were made by the Military Reform Act. However, SBP benefits will be subject to the changes made in the formula for determining cost-of-living adjustments.

(1) Survivor Social Security Offset

Coverage of military service under Social Security entitles the surviving spouse of a military retiree to receive Social Security survivor benefits based on the deceased retiree's active duty military service. The Military Survivor Benefit Plan is integrated with a portion of the deceased military member's retired pay to the surviving spouse, it was considered appropriate that all sources of survivor benefits attributable to military service be included in the survivor benefit computation. As a result, a limited amount of Social Security survivor benefits, payable because of military service, were subtracted from the SBP so that the SBP and Social Security together would provide at least 55 percent of the retired pay to the surviving spouse.

(2) The Two-Tiered SBP

Some have questioned the equity of the SBP. Military SBP benefits become payable immediately upon the death of the retiree, regardless of the age of the surviving spouse. Social Security widow(er)'s benefits are not paid until the survivor reaches age 60, while retirement benefits for a spouse with their own earnings record do not begin until age 62.

Under the "two-tier" system, if the surviving spouse is, for example, age 57 at the time of a retiree's death, full SBP benefits are payable immediately, and will continue until the survivor reaches age 62. Surviving spouses without their own Social Security earnings record are able to draw full benefits for several years before having them reduced. However, survivors who will receive their own retirement benefits from Social Security must wait for them until age 62, the point at which their SBP annuity is reduced. For survivors who are not eligible for any Social Security benefits, SBP annuities will be reduced even if they do not have additional retirement income when they reach age 62. This difference in treatment of survivors may lead to future legislative activity.

(3) Cost-of-Living Adjustment

Military retirees, along with Social Security and other Federal retirees, received a 5.4 percent COLA effective January 1, 1991.

3. Prognosis

No major legislative changes are expected in the military retirement system. A full COLA is in the President's budget for fiscal year 1992.

E. RAILROAD RETIREMENT SYSTEM

1. Background

The Railroad Retirement System is a federally managed retirement system covering employees in the rail industry, with benefits and financing coordinated with Social Security. The system was authorized in 1935, prior to the creation of Social Security, and remains the only federally administered pension program for a private industry. It covers all railroad firms and distributes retirement and disability benefits to employees, their spouses, and survivors. Benefits are financed through a combination of employee and employer payments to a trust fund, with the exception of vested so-called "dual" or "windfall" benefits, which are paid with annually appropriated Federal general revenue funds through a special account.

In fiscal year 1989, $9.6 billion in railroad retirement, disability, and survivor benefits were paid to 930,000 beneficiaries.

2. Issues and Congressional Response

(A) THE STRUCTURE OF THE RAILROAD RETIREMENT SYSTEM

In the final quarter of the 19th century, railroad companies were among the largest commercial enterprises in the Nation and were marked by a high degree of organizational centralization and integration. As first established in 1934, the Railroad Retirement System was designed to provide annuities to retirees based on rail earnings and length of service. However, the present Railroad Retirement System was a result of the Railroad Retirement Act of 1974, which fundamentally reorganized the program. Most significantly, the Act created a two-tier benefit structure in which Tier I was intended to serve as an equivalent to Social Security and Tier II as a private pension.

Tier I benefits of the Railroad Retirement System are computed on credits earned in both rail and nonrail work, while Tier II is based solely on railroad employment. The total benefit continued traditional railroad annuities and eliminated duplicate Social Security coverage for nonrail and rail employment.

The Bush administration has proposed to dismantle the Railroad Retirement System and replace it with a combination of direct Social Security coverage and a private administered rail pension. Past Congresses have rejected the proposal on the grounds that it could lead to a cut in benefits for present and future retirees and undermine confidence in the system.

(B) RECENT FINANCING PROBLEMS

(1) The 1983 Retirement Fund Crisis

Because Railroad Retirement benefits are financed by payroll tax revenues, the number of rail employees has always been a crucial factor in determining the financial viability of the system. Through the late 1970's, the rail industry was financially troubled, with falling rail traffic and employment opportunities. As a result, payroll tax revenues declined, leaving inadequately funded the 60–30 early retirement benefit (which allows workers with at least 30 years of experience to retire at age 60 with full Tiers I and II benefits as if age 65) initiated by the 1974 law and the vested "dual" benefit. By 1980, the Railroad Retirement Trust Fund was faced with financial difficulties and cash-flow problems.

Since the end of World War II, the worker/beneficiary ratio has been decreasing, as noted in the following table:

EMPLOYEES IN THE RAILROAD INDUSTRY AND BENEFICIARIES OF THE RAILROAD RETIREMENT SYSTEM SINCE 1945

[In thousands]

	Average employment	Beneficiaries	Ratio of workers to beneficiaries
Year:			
1945	1,680	210	8.04
1950	1,421	461	3.08
1955	1,239	704	1.76
1960	909	883	1.03
1965	753	930	.81
1970	640	1,052	.61
1975	548	1,094	.50
1980	532	1,084	.49
1981	503	999	.50
1982	440	988	.44
1983	395	981	.40
1984	395	980	.40
1985	372	954	.39
1986	342	941	.36
1987	320	928	.34
1988	302	915	.34

Source: Railroad Retirement Board, 1986, Annual Report, dated October 23, 1987.

The 1980 long-term financing problem worsened because congressional appropriations for "windfall" benefits were far from sufficient to pay for those benefits that year, and appropriations shortfalls consequently were paid from the Railroad Retirement Trust Fund. At the same time, funding for the 60–30 early retirement benefits had not been improved.

To improve the system's financial condition, Congress included a number of provisions in the Omnibus Budget Reconciliation Act of 1981 (P.L. 97–35) and the Economic Recovery Tax Act of 1981 (P.L. 97–34). Those provisions raised payroll taxes on employers and employees, modified benefits, created a separate account for windfall benefits, and provided the Railroad Retirement Trust Fund with authority to borrow from the General Treasury when near-term cash-flow difficulties arise.

Unfortunately, in the final quarter of 1982, an economic recession devastated the railroad industry and thwarted the intended benefits of the 1981 laws, bringing the Railroad Retirement System to the brink of insolvency and threatening a 40-percent cut in 1983 Tier II benefits. Another financial drain on the fund stemmed from borrowing from the fund by the Railroad Unemployment Insurance Account. By 1983, those unpaid borrowings totaled $575 million.

In 1983, rail labor and management, following congressional instructions, collectively negotiated a comprehensive rescue package and submitted it to Congress. As enacted in the Railroad Retirement Solvency Act of 1983 (P.L. 98-76), the package was composed of payroll tax increases, benefit reductions, and general revenue contributions, and was designed to ensure the solvency of the Railroad Retirement System through the 1990's, even under pessimistic employment assumptions. In the short-run, passage of the measure averted the threatened 40-percent reduction in Tier II benefits scheduled for 1983.

(2) The 1986–87 Fund Crisis

Following enactment of the Railroad Retirement Solvency Act of 1983, there was optimism that the retirement fund finally was on a firm financial foundation and that the decline in rail industry employment that had threatened the system would level off. In 1985, the Railroad Retirement Board (RRB) forecasted that the even substantial declines in rail employment would not bring about cash-flow problems in the next 10 to 20 years. However, the RRB did characterize the fund's long-term stability "still questionable."

Because the Tier II tax had not been increased and rail employment continued to decline, the chief actuary's 1987 report recommended that the Tier II tax be increased 4.5 percent, effective January 1, 1988. The report projected possible cash-flow problems as early as 2001, under pessimistic assumptions and the present financing structure. To address these concerns, the report also recommended that a panel be formed to examine possible sources of revenue for the system.

In response, the OBRA 1987, Public Law 100–203, increased the employer Tier II tax from 14.75 to 16.1 percent and the employee Tier II tax from 4.25 to 4.9 percent, up to an annual maximum taxable wage base, $51,300 in 1990. In addition, the Act increased revenue to the fund by an estimated additional $400 million by extending from October 1, 1988, to October 1, 1989, the cut-off date for transfer to the fund of revenue from the income taxation of Tier II and windfal benefits and removing the $877 million cap on such transfers. Acting on the recommendation in the 1987 report of the RRB's chief actuary, the Act ~~also~~ authorized the establishment of a Commission on Railroad Retirement Reform to report to the Congress on possible solutions to the system's long-term financial problems. The Commission submitted its final report in September 1990 which included numerous recommendations, including making the transfer of Title II tax to the Railroad Retirement Account Department. During the 101st Congress, Senator Heinz and Senator

Baucus introduced legislation (S. 2959) which extended the transfer of revenues through September 1992. This measure was included in OBRA 1990, thus ensuring the continued solvency of the Railroad Retirement system.

(3) Current Actuarial Status

In September 1990, the Commission on Railroad Retirement Reform issued a report concluding that the program is financially sound in the intermediate term. The report also said it was "not unlikely" that the system would remain sound over the next 75 years.

(C) THE RAILROAD UNEMPLOYMENT INSURANCE ACCOUNT DEBT

Prior to the 1983 Railroad Retirement Solvency Act, there were no requirements for repayment of the debt to the retirement fund. The debt was to be paid, in whole or in part, only if excess funds were available in the unemployment fund. The Act instituted the first tax for repayment of that debt.

Provisions in the COBRA 1985, enacted as Public Law 99-272, increased the rates of that tax.

In 1988, congressional concerns over the debt in the Railroad Retirement Fund led to the enactment of a number of provisions in the Technical and Miscellaneous Revenue Act of 1988 (P.L. 100-647). First, the Act increased the repayment tax rate to 4 percent, effective 1989, until the debt incurred prior to October 1, 1985, with interest, is repaid. Second, a new surcharge tax schedule was instituted. The surcharge will be 1.5 percent when the unemployment account's net assets fall below $100 million, 2.5 percent if less than $50 million, and 3.5 percent if below zero. Third, the Act required the RRB to submit a report to the Congress on July 1 of each year, commencing in 1989, on the status of the railroad unemployment insurance system.

(D) TAXATION OF RAILROAD RETIREMENT BENEFITS

(1) Taxation of Tier I

(a) The Social Security Act Amendments of 1983

In the Social Security Act Amendments of 1983 (P.L. 98-21) the Congress acted on a labor-management recommendation that Tier I benefits be subject to the same taxation as Social Security benefits. Consequently, the amount subject to tax is one-half of the excess of the total of adjusted gross income, plus one-half of the total Tier I benefits for the year, plus nontaxable interest income over the base of $25,000 for an individual ($32,000 for joint filers), not to exceed one-half of total Tier I benefits for that year. (Adjusted gross income does not include Tier I benefits.)

(b) The Railroad Retirement Solvency Act of 1983

The Railroad Retirement Solvency Act of 1983 (P.L. 98-76), established the Social Security Equivalent Benefit Account (SSEBA), under the Railroad Retirement System, separate from the Railroad Retirement Account (RRA). The Act provided that Tier II benefits paid after January 1, 1984, would be taxed as pension income. Pension income is taxable as ordinary income except for that portion contributed by the employee in excess of Social Security taxes (before 1974) and directly to Tier II (since 1982). This legislation also subjected windfall benefits paid after January 1, 1984, to taxation as ordinary income.

(c) The Consolidated Omnibus Budget Reconciliation Act of 1985

The COBRA 1985 restricted the Social Security income tax formula to only the part of a Tier I benefit equivalent to the amount of the SSEBA. The Act made the part of a Tier I benefit in excess of the non-SSEBA subject to the same tax as Tier II and all private pensions, effective the 1986 tax year.

The non-SSEBA is funded by employees' and employers' Tier II tax contributions, the same as are Tier II benefits. As a result, the RRB must annually make the necessary calculations to enable it to inform each annuitant of the amount of the Tier I benefit that is equivalent to Social Security and the amount, if any, that is in excess of the non-SSEBA. For fiscal years 1988 through 1993, the RRB has made the following projections of the respective SSEBA and non-SSEBA:

	SSEBA (billions)	Non-SSEBA (millions)
Fiscal year:		
1988	3.94	568
1989	4.11	571
1990	4.26	585
1991	4.41	591
1992	4.54	584
1993	4.61	587

(2) Taxation of Tier II Benefits

The Tax Reform Act of 1986 eliminated the 3-year rule for the recovery of private pension contributions, including the employee Tier II tax. Under that rule, the pension benefits did not become taxable until the total contribution of the annuitant was recovered in benefits over an initial period not to exceed 3 years. Under the 1986 change, the non-SSE portion of Tier I benefits and all of Tier II benefits become taxable immediately upon receipt, but on a prorated basis as to the annuitant's contributions, taking into consideration the life expectancy of the annuitant. The same rule applies to all private pensions.

(E) BENEFIT FORMULAS, QUALIFICATION RESTRICTIONS, AND LIMITATIONS

(1) "Last Person Service" Rule

Perhaps the most troublesome qualification rule was the "last person service" rule, which required a retiree to give up a job (full- or part-time) outside the rail industry to be eligible for an annuity. That rule became even more problematic in recent years because to reduce employment, many railroad employers instituted combined early retirement and separation pay plans applicable to employees who would not be eligible for Railroad Retirement benefits for many years after leaving that employment. Many former rail employees found satisfactory jobs in other industries, only to learn that they had to give up that employment to collect those benefits upon reaching the prescribed age. Under the rule, they could quit that job and apply for the benefits, then go to work for another employer (but not a railroad) and continue to receive the benefits, subject to the applicable earnings limitations. However, they could not return to work for the last non-railroad employer immediately preceding the application for benefits. This restriction applied to the spouse benefit as well as the retiree's benefit, part-time employment as well as full-time employment.

As a result of provisions enacted in the Technical and Miscellaneous Revenue Act of 1988 (P.L. 100-647), the last person service rule was replaced with a new rule, one which reduces the Tier II benefit by an amount equal to 50 percent of earnings from the last non-railroad employer, subject to the limitation that the total reduction in Tier II plus supplemental annuity benefits cannot be more than 50 percent. The new rule continues to apply at age 70 and beyond, but does not affect Tier I. In post-retirement employment, Tier I is affected only by the earnings limitations and the prohibition against railroad employment.

(2) Earnings Limitations

Tier I and vested dual benefits are subject to the same earnings limitations as Social Security: $1 deduction for each $2 earned over the limit. For 1991, the maximum earnings limits for the 65-69 age group is $9,720, and $7,080 for those under 65. In 1990, the deduction changes to $1 for each $3 earned over the limit for the 65-69 age group. The deduction remains the same for the 62-64 age group. From age 70 on, there is no earnings limitation.

During the first year of benefits only, the earnings limits are applied on a monthly basis only in those months in which the amount earned exceeds one-twelfth of the annual limit for that year. After the first year, the limits are applied to total annual earnings, without regard to either the number of months worked or the amount earned in any 1 month.

Those earnings limitations do not apply to Tier II, nor, in all cases, to all of Tier I. The earnings deduction cannot reduce the Tier I amount to an amount less than the Tier I amount would be, if computed only on the annuitant's railroad service through December 31, 1974, Also, the non-SSEBA portion of a Tier I benefit is not subject to a reduction for earnings over the limit.

Any railroad retiree contemplating returning to work should first ask the RRB's district office for a computation of the amount of the Tier I benefit that would not be subject to reduction for excess earnings.

Opponents of the earnings limitations claim it discourages the elderly from working and discriminates against those who need the additional income most—namely, those with lower-than-average

Social Security benefits. Conversely, those receiving the highest benefits can earn the same amount, without penalty.

A January 1989 Labor Department report, entitled "Older Worker Task Force: Key Policy Issues for the Future", cites that 61 percent of workers 63 and older are working because they "need the money." The report also points out that the "earnings test hurts those who must rely on earned income to supplement retirement income but does not affect those who have substantial income from savings." In 1986, according to the Labor Department, 48 percent of the males and 61 percent of the women 65 and older were working part-time. However, those statistics do not reveal what percentage of each group was working because they needed the income, nor the percentage who would prefer to work full-time.

(3) Social Security "Notch"/Railroad Retirement "Notch"

There seems to be no dispute that a result of the 1972 amendments followed by the 1977 amendments to the Social Security Act was comparatively lower benefits for those born after 1916 than for those born before 1917. Supporters of "corrective" legislation claim that this result was not intended by Congress and that the benefits of that group should be increased to bring their benefits more in line with the benefits of the group born before 1917. Proponents claim that the notch has already affected almost 10 million retirees, and that each year about 1.6 million new retirees born in the 1920's will experience the notch. On the other hand, opponents of the proposed legislation contend that the pre-1917 group are getting an unintended "bonanza", that the post-1916 birth group are receiving what was intended, and that "corrective" legislation would be too costly.

A 1988 GAO report on "The Notch Issue" concluded, among other things, that "Additional payments * * * through 1996 could range from about $20 billion to over $300 billion. Using current trust fund balances to finance notch remedies would slow attainment of minimum contingency reserve levels and could put the system at additional risk should there be an economic downturn. Also, in comparing the notch with patterns of income, assets, and health status, retirees likely to experience larger disparities have, on average, higher incomes and more assets. Those who tend to be in poorer health are more likely to experience smaller benefit disparities."

The GAO study also points out that: "Under 1983 legislation, current workers (who would be taxed to pay higher benefits to notch beneficiaries) already pay higher taxes than would be necessary under the pay-as-you-go concept to partially fund their own future benefits and reduce future workers' tax burden. Imposing additional taxes on these current workers to finance a higher replacement rate for the notch group (many of which already receive a higher replacement rate that can be anticipated by current workers) would raise significant issues of equity."

Nevertheless, as long as enough Social Security beneficiaries believe they are being victimized by notch, there likely will be legislative proposals in the Congress to address this issue. (For further discussion of this issue, please see chapter 1.)

3. Prognosis

The administration continues to push for privatization of the Railroad Retirement system. It is unlikely that Congress will agree to the proposal.

Chapter 3

TAXES AND SAVINGS

OVERVIEW

In both design and application, the Federal tax code long has reflected a recognition of the special needs of older Americans. Helping to preserve a standard of living threatened by reduced income, the loss of earning power, and increases in nondiscretionary expenditures has been a primary objective of tax policy relating to the elderly.

Until 1984, Social Security and Railroad Retirement benefits, like veterans' pensions, were exempt from Federal taxation. That year, to help restore financial stability to Social Security, up to half of Social Security and Railroad Retirement Tier I benefits of higher income beneficiaries became taxable under a formula contained in the Social Security Act Amendments of 1983 (P.L. 98-21).

The Tax Reform Act of 1986 (P.L. 99-514), resulted in a number of other changes to tax laws affecting older men and women. The Act repealed some longstanding tax advantages for elderly persons, while it increased personal exemptions and the standard deduction for the elderly. The impact of these changes will not be fully known until early in the next decade.

The Omnibus Budget Reconciliation Act of 1990 (OBRA 1990), also made a number of changes to the tax laws that might affect the tax burden of elderly persons. These include increases in excise taxes and the addition of a third rate.

A. TAXES

1. BACKGROUND

A number of longstanding provisions in the tax code are of special significance to older men and women. These include the exclusion of Social Security and Railroad Retirement Tier I benefits for low- and moderate-income beneficiaries, the tax credit for the elderly, and the one-time exclusion of up to $125,000 in capital gains from the sale of a home for persons at least 55 years of age.

The Tax Reform Act of 1986 repealed or altered to less advantageous effect a number of tax provisions of importance to older persons. At the same time, other changes made by the Act, such as the increase in the standard deduction provided for the elderly, may more than offset losses.

(A) TAXATION OF SOCIAL SECURITY AND RAILROAD RETIREMENT BENEFITS

For more than four decades following the establishment of Social Security, benefits were exempt from Federal income tax. The Congress did not explicitly exclude those benefits from taxation. Rather, their tax-free status arose from a series of rulings in 1938 and 1941 from what was then called the Bureau of Internal Revenue. These rulings were based on the determination that if Congress had intended to make Social Security benefits taxable, it would have provided the legislative authority to tax them when Social Security was created.

In 1983, the National Commission on Social Security Reform recommended that the Social Security benefits of higher income recipients be taxed, with the revenue put back into the Social Security trust funds. The proposal was part of a larger set of recommendations entailing financial concessions by employees, employers, and retirees alike to rescue Social Security from insolvency.

The Congress acted on this recommendation with the passage of the Social Security Act Amendments of 1983. As a result, up to one-half of the benefits of Social Security and Railroad Retirement recipients with incomes over $25,000 ($32,000 for joint filers) became subject to taxation. Since taxes already have been paid on the retired worker's share to the Social Security system, only the one-half regarded as the employer's contribution (and on which income taxes have not previously been paid) is taxable. In the case of Railroad Retirement recipients, only the Social Security-equivalent portion (Tier I) is affected. In 1987, approximately 12 percent of Social Security beneficiaries were subject to this tax.

The limited application of the tax on Social Security benefits reflects the congressional concern that lower- and moderate-income taxpayers not be subject to this tax. Because the tax thresholds are not indexed, however, with time, beneficiaries of more modest means will also be affected.

The tax treatment of Social Security benefits is noteworthy for another reason. Under the 1983 formula, Social Security income became the only initially tax-exempt income which can be pulled (up to 50 percent) into taxable income status by the total of other taxable income and tax-exempt interest income.

Revenues from the taxation of Social Security benefits have continued to increase. In 1984, approximately $3 billion in taxes were paid into the Social Security trust funds. In 1985, that figure rose to $3.4 billion, and in 1986, to $3.7 billion.

In 1987, as a result of the lower tax rates provided under the Tax Reform Act of 1986, tax revenues from Social Security are expected to slip to $3.5 billion. But they are expected to resume their climb each year thereafter. In 1991, the last year for which projections are available, these tax revenues are expected to exceed $5 billion.

(B) ELDERLY TAX CREDIT

Officially named the Tax Credit for the Elderly and the Permanently and Totally Disabled, Congress enacted the elderly tax credit in 1954 with the codification of the Internal Revenue Code. Under this provision, qualifying retirees receive a tax credit equal to 15 percent of the first $5,000 (for single filers) and $7,500 (for joint filers) both of which are qualified individuals.

Congress established the credit to correct inequities in the taxation of different types of retirement income. Prior to 1954, retirement income generally was taxable, while Social Security and railroad retirement (Tier I) benefits were tax-free. To provide roughly similar treatment of these different types of retirement income, the new provision allowed retirees, 65 and older, a tax credit equal to 15 percent of the total of all retirement income.

In the Social Security Act Amendments of 1983, the Congress limited the credit to those 65 and older, or disabled. That Act also increased the initial amounts which qualify for the credit.

(C) ONE-TIME EXCLUSION OF CAPITAL GAINS ON THE SALE OF A HOME

The one-time home sale capital gains exclusion originated in the Internal Revenue Act of 1964. It was viewed as a way to protect homeowners from incurring tax liability on gains which were thought to result largely from inflation. In addition, proponents asserted that the Government should not tax away assets people had accumulated for retirement through home-ownership, nor discourage elderly persons from selling their homes to reduce expenses or to move to smaller quarters.

Originally, capital gains of $20,000 of the adjusted sales price of the house for persons 65 and older were excluded. Over the years, Congress raised the maximum excludable gain to $125,000 to reflect increases in average market prices for housing and lowered to 55 the age at which the exclusion can be taken.

(D) TAX REFORM ACT OF 1986

The Tax Reform Act of 1986 made such sweeping changes to the Internal Revenue Code that the Congress chose to issue the Code as a completely new edition—something that has not occurred since 1954. As a result of the Act, the elderly were provided an increase in the amount of the standard deduction as well as other advantages available to the general population. Partially offsetting these benefits are the repeal of the extra personal exemption for the elderly (effective after 1987), the lowering in the medical deduction, and the end of the initial tax-free status of private pensions.

(1) Extra Personal Exemption for the Elderly

The extra personal exemption for elderly persons was enacted in 1948 to provide some relief from the effects of the postwar economy on the elderly. At that time, this provision removed an estimated 1.4 million elderly taxpayers and others (blind persons also were provided the extra personal exemption) from the rolls, and reduced the tax burden for another 3.7 million. Effective in 1987, the exemption was no longer available.

(2) Deduction of Medical and Dental Expenses

Under prior law, medical and dental expenses, including insurance premiums, copayments, and other direct out-of-pocket costs, were deductible to the extent that they exceeded 5 percent of a taxpayer's adjusted gross income. The 1986 tax law raised the threshold to 7.5 percent.

Since the elderly require more health care per capita than the nonelderly, the cut in the medical deduction could have a disproportionately negative impact on some elderly persons. Although persons 65 and older constitute about 12 percent of the population, their health care expenditures account for about one-third of the national total. In 1984, the annual average per capita expenditure for the elderly was $4,200, compared with $1,200 for those under 65. However, it should also be noted that the availability of Medicare lessens, to some extent, the importance of the medical deduction to elderly persons.

(3) Private Pensions

Prior to 1986, retirees under the Civil Service Retirement System or any other contributory pension plans generally had the benefit of the so-called 3-year rule. The effect of this rule was to exempt, up to a maximum of 3 years, pension payments from taxation until the amount of previously taxed employee contributions made during the working years was recouped. Once the employee's share was recouped, the entire pension became taxable.

Under the 1986 Act, the employer's contribution and previously untaxed investment earnings of the payment are calculated each month on the basis of the worker's life expectancy, and taxes are paid on the annual total of that portion. Retirees who live beyond their extimated lifetime then must begin paying taxes on the entire annuity, the rationale being that the retiree's contribution has been recouped and the remaining payments represent only the employer's contribution. For those who die before this point is reached, the law allows the last tax return filed on behalf of the deceased to treat the unrecouped portion of the pension as a deduction.

With a higher taxable income, some pensioners may be pushed into a higher tax bracket as a result of the provision. However, any initial tax increases are likely offset over the long run by the tax break on the retired worker's share of the pension during his or her estimated life time.

(4) Personal Exemptions and Standard Deductions

The Treasury Department annually adjusts personal exemptions and standard deductions for inflation. The personal exemption a taxpayer may claim on a return for 1990 is $2,050. The standard deduction is $3,250 for a single person, $4,750 for a head of household, $5,450 for a married couple filing jointly, and $2,725 for a married person filing separately.

(5) Filing Requirements and Exemptions

An estimated 6 million additional taxpayers—many of them elderly—were exempted from filing income tax forms under the 1986 tax law. The law raised the levels below which persons are exempted from filing Federal income tax forms. Single persons 65 or older do not have to file a return if their income is below $5,650. For married couples filing jointly, the limit is $9,400 if one spouse is 65 or older or $10,000 if both spouses are 65 or older. Persons who are claimed as dependents on another individual's tax return do not have to file a tax return unless their unearned income exceeds $500 or their gross income exceeds their maximum allowable standard deduction ($3,100 for persons 65 or older or blind, $3,700 for persons who are both 65 or older and blind).

2. ISSUES

(A) THE IMPACT OF TAX REFORM OF 1986

One study prepared for the American Association of Retired Persons concludes that the 1986 tax reform measure ultimately will remove about 2 percent of the elderly from the tax rolls, and that tax payments for this age group as a whole will decline overall by about 1 percent. The study also concludes that on the whole the benefits of the new code to the elderly are substantially less than those to the nonelderly. Average tax savings are estimated at $18 and $401, respectively, for the two groups.

(B) INCENTIVES FOR RURAL PRIMARY CARE

Despite increased numbers of physicians, it remains difficult to impossible to attract needed physicians to medically underserved and remote rural areas. Further exacerbating this problem is that up to 25 percent of rural physicians will retire or relocate within the next 5 years. Without a concerted effort of Federal and State governments, elderly persons living in rural areas will increasingly find it impossible to receive necessary health care.

In response, Senator David Pryor introduced the Rural Primary Care Incentives Act of 1989, S. 1060. The legislation would provide primary care physicians who practice in federally designated high priority health manpower shortage areas a tax credit of $12,000 per year for 3 years based on a 5-year service incentive. Additionally, it would eliminate the taxable status of funds given to health personnel through the National Health Services Corporation Loan Repayment Program.

B. SAVINGS

1. BACKGROUND

Since 1981, there has been considerable emphasis on increasing the amount of capital available for investment. By definition, increased investment must be accompanied by an increase in savings. Total national savings comes from three sources: Individuals saving their personal income, businesses retaining their profits, and the Government savings when tax revenues exceed expenditures. As part of the trend to increase investment generally, new or expanded incentives for personal savings and capital accumulation have been enacted in recent years.

At the same time, retirement income experts have suggested that incentives for personal savings be increased to encourage the accumulation of greater amounts of retirement income. Many retirees are dependent primarily on Social Security for their income. Thus, some analysts favor a better balance between Social Security, pensions, and personal savings as sources of income for retirees. The growing financial crisis that faced Social Security in the early 1980's reinforced the sense that individuals should be encouraged to increase their preretirement savings efforts.

The life-cycle theory of savings has helped support the sense that personal savings is primarily saving for retirement. This theory postulates that individuals save little as young adults, increase their savings in middle age, then consume those savings in retirement. Survey data suggests that savings habits are largely dependent on available income versus current consumption needs, an equation that changes over the course of most individuals' lifetimes.

The consequences of the life-cycle savings theory raises questions for Federal savings policy. Tax incentives may have their greatest appeal to those already saving at above-average rates—taxpayers who are reaching maturity, earning above-average incomes, and subject to relatively high marginal tax rates. Whether this group presently is responding to these incentives by creating new savings or simply shifting after-tax savings into tax-deferred vehicles is a continuing subject for disagreement among policy analysts. For taxpayers who are young or have lower incomes, the tax incentives may be of little value. Expanding savings in this group necessitates a trade-off of increased savings for current consumption, a behavior which they are not under most circumstances inclined to pursue. As a result, some observers have concluded that tax incentives will contribute little to the adequacy of retirement income for most individuals, especially those at the lower end of the income spectrum.

The dual interest of increased capital accumulation and improved retirement income adequacy has sparked an expansion of tax incentives for personal retirement savings over the last decade. However, in recent years, Congress has begun to question the importance and efficiency of expanded tax incentives for personal savings as a means to raise capital for national investment goals, and as a way to create significant net new retirement savings. These issues received attention in 1986 as part of the effort to improve the fairness, simplicity, and efficiency of Federal tax incentives.

The role of savings in providing income in retirement has increased gradually over the last decade as new generations of older Americans with greater assets have reached retirement. In 1986, 26 percent of elderly income came from assets, compared with only 16 percent in 1962. Fully, 67 percent of the elderly had some income from assets in 1984, compared with 54 percent in 1962.

The distribution of asset income varies for different elderly subgroups. As 1986 figures indicate, the oldest old are less likely to have asset income than the younger elderly. Only 62 percent of those 80 and older had asset income in 1986, compared with 68 percent of those in the 65–69 age group. In 1986, 71 percent of elderly men had asset income, compared with 66 percent of elderly women. Whites are more than twice as likely to have asset income as other races; 71 percent of elderly whites had asset income, compared to only 30 percent for blacks and 31 percent of the elderly of Spanish origin.

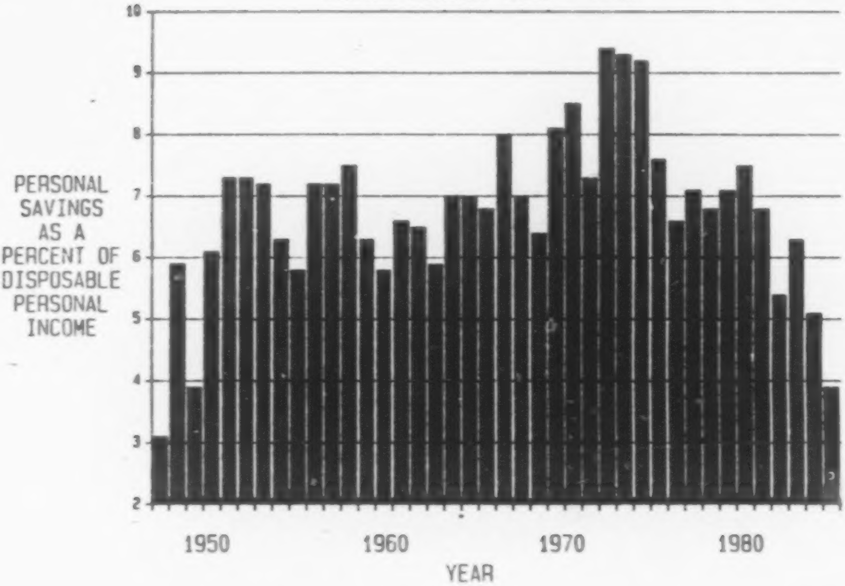
Finally, the likelihood of asset income receipt is directly proportional to total income. Asset income is much more prevalent among individuals with high levels of retirement income. Only 27 percent of elderly persons with incomes less than $5,000 receive income from assets, while 84 percent of those with incomes between $10,000 and $20,000 and 95 percent of those with income over $20,000 receive some asset income. One-third of the elderly with incomes greater than $20,000 relied on assets to provide more than half of their retirement income, while only 11 percent of those with income less than $5,000 relied on assets for more than half their retirement income.

Historically, income from savings and other assets has furnished a small but growing portion of total retirement income. Assets remain a far more important source of income for the retired population on the whole than pension annuities, largely because less than one in three retirees receive pension benefits.

The effort to increase national investment springs from a perception that governmental, institutional, and personal savings rates are lower than the level necessary to support a healthy economy. Except for a period during World War II when personal savings approached 25 percent of income, the personal savings rate in the United States has ranged between 5 percent and 8 percent of disposable income. (Chart 1 shows the variation in personal savings rates as a function of disposable personal income from 1947–87.) Many potential causes for these variations have been suggested, including demographic shifts in the age and composition of families and work forces and efforts to maintain levels of consumption in the face of inflation. Personal savings rates in the United States historically have been substantially lower than in other industrialized countries. In some cases it is only one-half to one-third of the savings rates in European countries.

CHART 1

PERSONAL SAVINGS RATE
UNITED STATES: 1947 - 1987



SOURCE: National Income Product Accounts. Bureau of Economic Analysis, Department of Commerce.

For 1987, Commerce Department figures indicate that the personal savings rate was 3.8 percent, about the same as 1986. For the third and fourth quarters of 1987, the rates were 2.8 percent and 4.5 percent, respectively. Analysts suggest that without savings in corporate pensions, the country actually experienced a decline in savings overall. In part, this dramatically low figure may reflect an increased tendency to purchase goods on consumer credit. Given the additional expansion of tax incentives for retirement savings in recent years, the low rate of personal savings raises serious doubts about the effectiveness of those incentives. If retirement savings only take place in employer-sponsored plans, then policy analysts argue that retirement income goals might be better served by policies favoring these, rather than individual savings vehicles.

Even assuming present tax policy creates new personal savings, critics suggest this may not guarantee an increase in total national savings available for investment. Federal budget surpluses constitute savings as well; the loss of Federal tax revenues resulting from the tax incentives may offset the new personal savings being generated. Under this analysis net national savings would be increased only when net new personal savings exceeded the Federal tax revenue foregone as a result of tax-favored treatment.

Recent studies of national retirement policy have recommended strengthening individual savings for retirement. Because historical rates of after-tax savings have been low, emphasis has frequently been placed on tax incentives to encourage savings in the form of voluntary tax-deferred capital accumulation mechanisms.

The final report of the President's Commission on Pension Policy issued in 1981 recommended several steps to improve the adequacy of retirement savings, including the creation of a refundable tax credit for employee contributions to pension plans and individual retirement savings. Similarly, the final report of the National Commission on Social Security recommended increased contribution limits for IRA's. In that same year, the Committee for Economic Development—an independent, nonprofit research and educational organization—issued a report which recommended a strategy to increase personal retirement savings that included tax-favored contributions by employees covered by pension plans to IRA's, Keogh plans, or the pension plan itself.

These recommendations reflected ongoing interest in increased savings opportunity. In each Congress since the passage of the Employee Retirement Income Security Act (ERISA) in 1974, there have been expansions in tax-preferred savings devices. This continued with the passage of the Economic Tax Recovery Act of 1981 (ERTA). From the perspective of retirement-specific savings, the most important provisions were those expanding the availability of IRA's, simplified employee pensions, Keogh accounts, and employee stock ownership plans (ESOP's). ERTA was followed by additional expansion of Keogh accounts in the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA), which sought to equalize the treatment of contributions to Keogh accounts with the treatment of contributions to employer-sponsored defined contribution plans.

The evolution of Congress' attitude toward expanded use of tax incentives to achieve socially desirable goals holds important implications for tax-favored retirement savings. When there is increasing competition for Federal tax expenditures, the continued existence of tax incentives depends in part on whether they can stand scrutiny on the basis of equity, efficiency in delivering retirement benefits, and their value to the investment market economy.

2. Issues

(A) INDIVIDUAL RETIREMENT ACCOUNTS (IRA'S)

(1) Pre-1986 Tax Reform

The extension of IRAs to pension-covered workers in 1981 by ERTA resulted in dramatically increased IRA contributions. In 1982, the first year under ERTA, IRS data showed 12.1 million IRA accounts, nearly four times the 1981 number. In 1983, the number of IRAs rose to 13.6 million, 15.2 million in 1984, and 16.2 million in 1985. In 1986, contributions to IRAs totalled $38.2 billion. The Congress anticipated IRA revenue losses under ERTA of $980 million for 1982 and $1.35 billion in 1983. However, according to Treasury Department estimates, revenue losses from IRA deductions for those years were $4.8 billion and $10 billion, respectively. By 1986, the estimated revenue loss had risen to $16.8 billion. Clearly, the program had become much larger than Congress anticipated.

The rapid growth of IRAs posed a dilemma for employers as well as Federal retirement income policy. The increasingly important role of IRAs in the retirement planning of employees began to diminish the importance of the pension bond which links the interests of employers and employees. Employers began to face new problems in attempting to provide retirement benefits to their work forces.

A number of questions arose over the efficiency of the IRA tax benefit in stimulating new retirement savings. First, does the tax incentive really attract savings from individuals who would be unlikely to save for retirement otherwise? Second, does the IRA tax incentive encourage additional savings or does it merely redirect existing savings to a tax-favored account? Third, are IRAs retirement savings or are they tax-favored savings accounts used for other purposes before retirement?

Evidence indicated that those who used the IRA the most might otherwise be expected to save without a tax benefit. Low-wage earners barely used IRAs. The participation rate among those with less than $20,000 income was two-fifths that of middle-income taxpayers ($20,000–$50,000 annual income) and one-fifth that of high-income taxpayers ($50,000 or more annual income). Also, younger wage earners, as a group, were not spurred by the IRA tax incentive. As the life-cycle savings hypothesis suggests, employees nearing normal retirement age are three times more likely to contribute to an IRA than workers in their twenties. Those without other retirement benefits also appear to be less likely to use an IRA. Employees with job tenures greater than 5 years display a higher propensity toward IRA participation at all income levels. For those not covered by employer pensions, utilization generally increases with age, but is lower across all income groups than for those who are covered by employer pensions. In fact, 46 percent of IRA accounts are held by individuals with vested pension rights.

Though a low proportion of low-income taxpayers utilize IRAs relative to higher income counterparts, those low-income individuals who do contribute to an IRA are more likely than their high-income counterparts to make the contributions from salary rather than pre-existing savings. High-income taxpayers apparently are more often motivated to contribute to IRAs by a desire to reduce their tax liability than to save for retirement.

One of the stated objectives in the creation of IRAs was to provide a tax incentive for increased savings among those in greatest need. This need appears to be most pressing among those with low pension coverage and benefit receipt resulting from employment instability or low average career compensation. However, the likelihood that a taxpayer will establish an IRA increases with job and income stability. Thus, the tax incentive appears to be most attractive to taxpayers with relatively less need of a savings incentive. As a matter of tax policy, IRAs could be an inefficient way of improving the retirement income of low-income taxpayers.

An additional issue was whether all IRA savings are in fact retirement savings or whether IRAs were an opportunity for abuse as a tax shelter. Most IRA savers probably view their account as retirement savings and are inhibited from tapping the money by the early 10-percent penalty on withdrawals before age 59½. However, those who do not intend to use the IRA to save for retirement, can still receive tax benefits from an IRA even with early withdrawals. Most analysts agree that the additional buildup of earnings in the IRA, that occurs because the earnings are not taxed will surpass the value of the 10-percent penalty after only a few years, depending upon the interest earned. Some advertising for IRA savings emphasized the weakness of the penalty and promoted IRAs as short-term tax shelters. Although the tax advantage of an IRA is greatest for those who can defer their savings until retirement, they are not limited to savings deferred for retirement.

An additional concern is that the IRA was not equally available to all taxpayers who might want to save for retirement. Nonworking spouses of workers saving in an IRA could contribute only an additional $250 a year. Some contended that this created an inequity between two-earner couples who could contribute $4,000 a year and one-earner couples who could contribute only $2,250 in the aggregate. They argued that it arbitrarily reduces the retirement income of spouses, primarily women, who spend part of all of their time out of the paid work force. Those who opposed liberalization of the contribution rules contended that any increase would primarily advantage middle- and upper-income taxpayers, since the small percentage of low-income taxpayers who utilized IRAs often did not contribute the full $2,000 permitted them each year.

(2) Post-1986 Tax Reform

The IRA provisions of the 1986 Tax Reform Act were among the most significant changes affecting individual savings for retirement. To focus the deduction more effectively on those who need it, the Act repealed the deductibility of IRA contributions for pension plan participants and their spouses, with an adjusted gross income (AGI) in excess of $35,000 (individual) or $50,000 (family). For pension-covered workers and their spouses with AGI's between $25,000 and $35,000 (individual) or $40,000 and $50,000 (family) the maximum deductible IRA contribution is reduced in relation to their incomes. Workers in families without pensions, and pension-covered workers with AGIs below $25,000 (individual) and $40,000 (family) retain the $2,000 per year IRA contribution. Even with the loss of the IRA deduction for some workers, however, all IRA accounts, even those receiving only after-tax contributions, continue to accumulate earnings tax free.

(B) RESIDENTIAL RETIREMENT ASSETS

(1) Pre-1986 Tax Reform

Tax incentives, which have long promoted the goal of home ownership, include the income tax deductions for real estate taxes and home mortgage interest. As in the one-time exclusion of capital gains on the sale of a home, these tax breaks recognize that for many elderly persons a home may represent their principal or only retirement asset.

(2) Post-1986 Tax Reform

Prior to the 1986 Tax Reform Act, all real estate mortgage interest was tax deductible. To generate new Federal revenues, the Act limited the deduction to interest on home mortgages or home equity loans taken out on principal residence or a second home to purchase a home, make home improvements, or pay medical or educational expenses. Thus, interest paid on any part of the loan used for other purposes no longer qualifies for the deduction. (The deduction for real estate taxes remains unchanged.)

The home mortgage interest deduction was further restricted under OBRA 1986. The Act placed a ceiling on the amount of a mortgage that qualifies for the tax deduction. For loans used to acquire or improve a principal or second residence, the limit is $1 million. For home loans used for other debt purposes (limitation to medical or educational debts eliminated), the cap is $100,000.

C. THE OMNIBUS BUDGET RECONCILIATION ACT OF 1990

The OBRA 1990 made a number of substantial changes to the Internal Revenue Code. It replaces the previous two rates with a three rate structure: 15 percent, 28 percent, and 31 percent. Starting in the 1991 tax year, the new 31 percent rate will apply to single individuals with taxable income (not gross income) of $49,200 or more. It will apply to joint filers with taxable income of $82,050 or more, to single heads of households with taxable incomes of $70,350 or more, and to married individuals filing separately with taxable income of $41,025 or more. The Act sets the maximum tax rate of 28 percent on the sale of capital assets.

The Act also repeals the so-called "bubble" from the Tax Reform Act whereby middle income taxpayers paid higher marginal rates on certain income as a phase out of personal exemptions and the lower 15 percent rate. However, the Act in effect creates a new "bubble" for higher income taxpayers by phasing out personal exemptions and limiting itemized deductions. The phase out of personal exemptions begins at $100,000 for single filers, $150,000 for joint filers, $125,000 for heads of households, and $75,000 for married individuals filing separately. The Act limits the value of itemized deductions by 3 percent of the amount a taxpayer's adjusted gross income exceeds $100,000.

Additionally, the Act raises excise taxes on alcoholic beverages, cigarettes, gasoline, and certain luxury items like yachts, high-priced cars, and expensive furs and jewelry. To offset the possible regressive effects of some of the excise taxes, Congress increased the earned income tax credit for low-income families.

On the positive side, the Act provides a tax credit to help small businesses attempting to comply with the Americans With Disabilities Act. The bill, sponsored by Senators Pryor, Kohl, and Hatch, allows small businesses a 50-percent credit for expenditures of between $250 and $10,250 in a year to make their businesses more accessible to disabled persons. Such expenditures can include amounts spent to remove physical barriers and to provide interpreters, readers, or equipment that make materials more available to the hearing or visually impaired. To be eligible, a business must have grossed less than $1 million in the preceding year or have no more than 30 full-time employees.

According to estimates provided by the Congressional Budget Office, most elderly persons should be fairly untouched by the changes made by the 1990 Act. However, many high-income elderly will pay higher taxes. A number of the excise taxes will have a negative effect on all the elderly, particularly the 5 cents a gallon increase on gasoline. Like all changes of the tax laws, certain individuals will be negatively affected, but as a class the elderly will pay the same or even less in Federal income taxes after the 1990 Act.

Chapter 4

EMPLOYMENT

OVERVIEW

The time that older Americans spend in retirement has dramatically lengthened in recent years. Not only are people living longer, but many are choosing to retire at a much earlier age. In fact, early retirement is a concept that is fast becoming a part of the American way of life. However, a growing number of persons desire or need to work in their later years. For them, age discrimination often is an obstacle.

Age, like race, sex, religion, and national origin, is a protected category under Federal law. Eliminating age bias in the workplace is consistent with the American tradition of barring arbitrary policies that discriminate against individuals on the basis of their beliefs or personal characteristics. The nearly unanimous opposition to mandatory retirement by the American public indicates a strong sentiment against age-based employment policies. Nevertheless, statutory protections against age discrimination remain incomplete and somewhat ineffective.

While the unemployment rate for older persons is approximately half that of younger persons, once an older worker loses a job, his or her duration of unemployment tends to be much longer. A report by the Congressional Research Service, U.S. Library of Congress, entitled "A Demographic Portrait of Older Workers," shows that in 1989, workers age 55 to 64 were out of work for an average of 17.7 weeks, while workers age 65 and over were unemployed for an average of 14.1 weeks. The average length of unemployment for all workers age 16 and over was 11.9 weeks.

A. BACKGROUND

1. Age Discrimination

Numerous obstacles to older worker employment persist in the workplace, including negative stereotypes about aging and productivity; job demands and schedule constraints that are incompatible with the skills and needs of older workers; and management policies that make it difficult to remain in the labor force, such as early retirement incentives. For the most part, these obstacles have their roots in age discrimination.

Age discrimination in the workplace plays a pernicious role in blocking employment opportunities for older persons. The development of retirement as a social pattern has helped to legitimize this form of discrimination. Indeed, retirement is a concept which has become imbedded in the American consciousness.

Although there is no agreement on the extent of age-based discrimination, nor how to remedy it, few would argue that the problem exists for millions of older Americans. Despite Federal laws banning most forms of age discrimination in the workplace, most Americans view age discrimination as a serious problem. Two nationwide surveys conducted by Louis Harris & Associates, in 1975 and in 1981, found nearly identical results: 8 out of 10 Americans believe that "most employers discriminate against older people and make it difficult for them to find work."

The public's perception of widespread age discrimination also is shared by a majority of business leaders. According to a 1981 nationwide survey of 552 employers conducted by William M. Mercer, Inc., 61 percent of employers believe older workers are discriminated against on the basis of age; 22 percent claim it is unlikely that, without negative legal consequences, a company would hire someone over age 50 for a position other than senior management; 20 percent admit that older workers, other than senior executives, have less opportunity for promotions or training; and, 12 percent admit that older workers' pay raises are not as large as those of younger workers in the same category.

The pervasive belief that all abilities decline with age has fostered the myth that older workers are less efficient than younger workers. The forms of age discrimination range from the more obvious, such as age-based hiring or firing, to the more subtle, such as job harassment and early retirement incentives. Part of this problem is that younger workers, rather than old workers, tend to receive the skills and training needed to keep up with technological changes. Too often, employers wrongly assume that it is not financially advantageous to retrain an older worker. They believe that a younger employee will remain on the job longer, simply because of his or her age. In fact, the mobility of today's work force does not suggest greater longevity on the part of a young worker. According to the Bureau of Labor Statistics, the median job tenure for a current employee is as little as 4.2 years.

Other discriminatory practices involve relocating an older employee to an undesirable area in the hopes that the employee will instead resign, or giving an older employee poor evaluations to justify the employee's later dismissal.

Age-based discrimination in the workplace poses a serious threat to the welfare of many older persons. While the number of older persons receiving maximum Social Security benefits is increasing, most retirees receive less than the maximum. According to the 1989 edition of the U.S. Senate Special Committee on Aging's report entitled "Aging America: Trends and Projections," in 1988, 73 percent of persons aged 65 or older had a total annual income of less than $15,000. Other reports reveal that only slightly more than half of the workforce is covered by a private pension plan, and most older persons do not have substantial holdings in savings, stocks, insurance policies, or bonds.

According to the National Commission for Employment Policy, in 1980, several million older workers suffered severe labor market problems, including unemployment or underemployment. CRS's "A Demographic Portrait of Older Workers" reports that in 1989 the unemployment rate was 3.2 percent for workers age 55 to 64, 3 percent for workers age 65 to 69, and 2.1 percent for workers age 70 and over. Although older workers as a group have the lowest unemployment rate, these numbers do not reflect those older individuals who have withdrawn completely from the labor force due to a belief that they cannot find satisfactory employment. Duration of unemployment is also significantly longer among older workers.

According to the Bureau of Labor Statistics (BLS), because older job seekers are more likely to be unemployed for a longer period than younger persons, they are more likely to exhaust available unemployment insurance benefits and suffer economic hardships. The 1978 Employment and Training Report of the President indicates that the problems of older unemployed workers are worsened by the fact that many persons over 45 still have significant financial obligations.

Not surprisingly, evidence suggests that there is a link between the longer duration of unemployment for older workers and the higher rate of discouraged workers in this age group. For men age 65 and over, the annual average level of discouraged workers is almost as large as the number of unemployed. The BLS reports that the prospects of an older male worker finding work are so low that he is three times more likely to become discouraged than his younger counterpart. Further, when older workers are fortunate enough to find work, they generally face a cut in earnings and experience a diminished status compared to their previous employment.

Psychologists report that discouraged workers can face serious psychological stress, including hopelessness, depression, and frustration. In addition, medical evidence suggests that forced retirement can so adversely affect a person's physical, emotional, and psychological health that a life span may be shortened. According to the American Association of Retired Persons (AARP), 30 percent of the Nation's retirees are believed to suffer from serious adjustment problems.

Although the attitude persists that older workers can hinder productivity, there is also a growing recognition of their value. A 1985 study by Waldman and Avolio revealed little evidence to support the "somewhat widespread belief that job performance declines with age." Among their findings was a strong correlation between improved performance and increasing age, especially in objective measures of productivity. They concluded that "although chronological age may be a convenient means for estimating performance potential, it falls short in accounting for the wide range of individual differences in job performance for people at various ages."

Many employers have reported that older workers stay on the job longer than younger workers. Some employers have recognized that older workers can offer experience, reliability, and loyalty. A 1989 AARP survey of 400 businesses reported that older workers generally are regarded very positively and are valued for their experience, knowledge, work habits, and attitudes. In the survey, employers gave older workers their highest marks for productivity, attendance, commitment to quality, and work performance.

Gradually, discriminatory attitudes toward older workers are changing, but much more must be done to ensure employment opportunities for older workers. At present, it is clear that age discrimination is reducing the work efforts of older persons, encouraging premature labor force withdrawal, and increasing the burden on Social Security and private pensions. Without effective solutions to age discrimination in the workplace, these problems will persist.

(A) THE AGE DISCRIMINATION IN EMPLOYMENT ACT

Over two decades ago, the Congress enacted the Age Discrimination in Employment Act of 1967 (ADEA) (P.L. 90-202) "to promote employment of older persons based on their ability rather than age; to prohibit arbitrary age discrimination in employment; and to help employers and workers find ways of meeting problems arising from the impact of age on employment."

In large part, the ADEA arose from a 1964 executive order issued by President Johnson declaring a public policy against age discrimination in employment. Three years later, the President called for congressional action to eliminate age discrimination. The ADEA was the culmination of extended debate concerning the problems of providing equal opportunity for older workers in employment. At issue was the need to balance the right of the older workers to be free from age discrimination in employment with the employers' prerogative to control managerial decisions. The provisions of the ADEA attempt to balance these competing interests by prohibiting arbitrary age-based discrimination in the employment relationship. The law provides that arbitrary age limits may not be conclusive in determinations of nonemployability, and that employment decisions regarding older persons should be based on an individual assessment of each older worker's potential or ability.

As originally enacted, the ADEA prohibited employment discrimination against persons aged 40 to 65. As a result of amendments to the law in 1986, however, there currently is no upperlimit cap on these protections, except in a select few professions. The ADEA now covers virtually all employees 40 years of age or older.

Under the ADEA actions otherwise deemed unlawful may be permitted only if they are based upon the following considerations: (1) Where age is a bona fide occupational qualification reasonably necessary to normal operations of a particular business; (2) where differentiation is based on reasonable factors other than age (e.g., the use physical examinations relating to minimum standards reasonably necessary for specific work to be performed on a job); (3) to observe the terms of a bona fide seniority system or a bona fide employee benefit plan such as a retirement, pension, or insurance plan, with the qualification that no seniority system or benefit plan may require or permit the involuntary retirement of any individual who is covered by the ADEA; and (4) where an employee is discharged for good cause. Also, an executive or high-ranking, policymaking employee in the private sector who is entitled to annual private retirement benefits of at least $44,000 can be compulsorily retired at age 65, simply because of age. This is known as the "executive exemption," and it was designed to allow turnover at the top levels of an organization. While the exemption has strong support among business leaders, recent evidence shows that it is used only infrequently by a small number of employers.

Since it's enactment in 1967, the ADEA has been amended a number of times. The first set of amendments occurred in 1974, when the law was extended to include Federal, State, and local government employers. The number of workers covered also was increased by limiting exemptions for employers with fewer than 20 employees. (Previous law exempted employers with 25 or fewer employees.) In 1978, the ADEA was amended by extending protections to age 70 for private sector, State, and local government employers, and by removing the upper age limit for employees of the Federal Government.

In 1982, the ADEA was amended by the Tax Equity and Fiscal Responsibility Act (TEFRA) to include the so-called "working aged" clause. As a result, employers are required to retain their over-65 workers on the company health plan rather than automatically shifting them to Medicare. Under previous law, Medicare was the primary payer and private plans were secondary. TEFRA reversed the situation, making Medicare the payer of last resort. While this provision was designed to be a cost-saver for Medicare, it poses an obstacle to employment for older workers because it increases the cost of their employment.

Amendments to the ADEA were also contained in the 1984 reauthorization of the Older Americans Act (P.L. 98-459). Under the 1984 amendments, the ADEA was extended to U.S. citizens who are employed by U.S. employers in a foreign country. Support for this legislation stemmed from the belief that such workers should not be subject to possible age discrimination just because they are assigned abroad. Also, the executive exemption was raised from $27,000 to $44,000, the annual private retirement benefit level used to determine the exemption from the ADEA for persons in executive or high policymaking positions.

The Age Discrimination in Employment Act Amendments of 1986 (P.L. 99-592) contained provisions that eliminated mandatory retirement altogether. By removing the upper age limit, Congress sought to protect workers age 40 and above against discrimination in all types of employment actions, including forced retirement, hiring, promotions, and terms and conditions of employment.

Currently, there are approximately 3 million Americans age 65 and over in the work force. Many of them continue to work for reasons of self-fulfillment, but more often they work because of economic necessity. The 1986 amendments to the ADEA also extended through the end of 1993 an exemption from the law for institutions of higher education and for State and local public safety officers.

In 1990, Congress amended the ADEA by enacting the Older Workers Benefit Protection Act (P.L. 101-433). This legislation restored and clarified the ADEA's protection of the employee benefits of our Nation's older workers. In addition, it established new protections for workers who are asked to sign waivers of their ADEA rights. These significant and important changes in the ADEA are discussed in the "Issues and Responses" section of this chapter.

(B) THE EQUAL EMPLOYMENT OPPORTUNITY COMMISSION

The Equal Employment Opportunity Commission (EEOC) is responsible for enforcing laws prohibiting discrimination. These include: (1) Title VII of the Civil Rights Act of 1964; (2) The Age Discrimination in Employment Act of 1967; (3) The Equal Pay Act of 1963; and (4) Sections 501 and 505 of the Rehabilitation Act of 1973.

When originally enacted, enforcement responsibility for the ADEA was placed with the Department of Labor (DOL) and the Civil Service Commission. In 1979, however, the Congress enacted President Carter's Reorganization Plan No. 1, which called for the transfer of responsibilities for ADEA administration and enforcement to the EEOC effective July 1, 1979.

Since taking over responsibility for the ADEA, the EEOC has alternately been praised and criticized for its performance in enforcing the ADEA. In recent years, concerns have been raised over EEOC's decision to refocus its efforts from broad complaints against large companies and entire industries to more narrow cases involving few individuals. Critics also point to the large gap between the number of age-based complaints filed and the EEOC's modest litigation record. In fiscal year 1989, the EEOC received 14,789 complaints and filed only 133 suits on behalf of complainants.

2. FEDERAL PROGRAMS

The Federal Government provides funds for training disadvantaged and dislocated workers to assist them in becoming more employable. Two important Federal programs designed to promote the employment opportunities of older workers are the Job Training Partnership Act program and the Senior Community Service Employment Program under Title V of the Older Americans Act.

(A) THE JOB TRAINING PARTNERSHIP ACT

The Job Training Partnership Act (JTPA), enacted in 1982, established a nationwide system of job training programs administered jointly by local governments and private sector planning agencies. For the program year from July 1, 1991, through June 30, 1992, $4.1 billion has been appropriated. This compares to the $3.9 billion appropriated for JTPA in fiscal year 1990.

JTPA establishes two major training programs: Title II for economically disadvantaged youth and adults, with no upper age limit; and Title III for dislocated workers, including those long-term unemployed older workers for whom age is a barrier to reemployment. Under the Title II-A program, which authorizes training for disadvantaged youth and adults, funds are allotted among States according to the following three equally weighted factors: (1) number of unemployed individuals living in areas with jobless rates of at least 6.5 percent for the previous year; (2) number of unemployed individuals in excess of 4.5 percent of the State's civilian labor force; and (3) the number of economically disadvantaged individuals. Training under Title II-A can include on-job training, classroom training, remedial education, employability development, and a limited amount of work experience. For the period July 1, 1988, through June 30, 1989, 36,730 persons age 55 and older participated in the Title II-A program, representing 5 percent of total adult participants.

Section 124(a-d) of JTPA also establishes a statewide program of job training and placement for economically disadvantaged workers age 55 or older. Governors are required to set aside 3 percent of their Title II-A allotments for this older workers program. The older workers program under section 124 of JTPA is meant to be operated in conjunction with public agencies, private nonprofit organizations, and private industries. Programs must be designed to assure the training and placement of older workers in jobs with private business concerns. During program year 1988, 38,224 persons age 55 and older were served under this program.

Title III is for workers who have been or are about to be laid off, workers who are eligible for or who have exhausted their entitlement to unemployment compensation, and workers who are unlikely to return to their previous occupation or industry. The dislocated workers program is administered by the States and provides such services as job search assistance, job development, training in job skills which are in demand, relocation assistance and activities conducted with employers or labor unions to provide early intervention in case of a plant closing. During the period between July 1, 1988 and June 30, 1989, approximately 8,048 persons age 55 and over were served by the Title III program (about 8 percent of total program participants).

As a result of the enactment of the Worker Adjustment and Retraining Act of 1988 (P.L. 100-379), the Title III program was significantly restructured and further funding was authorized. Under previous law, Title III had been similar to a block grant program, with few specific Federal standards imposed. However, the new law required States to establish a number of specific subgroups to carry out the program and to place a stronger emphasis on job training. The new program began in July 1989.

According to 1987 findings of the National Commission for Employment Policy (NCEP), the JTPA is working well and, with minor exceptions, is meeting its legislative mandate. The report did acknowledge that conversations with State Job Training Coordination Council chairs confirmed that some States are having difficulty using the 3 percent set-aside funds for older workers due to recruitment problems and difficulty in placing this population.

A 1990 GAO Fact Sheet titled "Job Training Partnership Act: Information on Set-Aside Funding for Assistance to Older Workers," prepared for Senator David Pryor, confirmed the underspending of the 3 percent set-aside funds. However, GAO found that usage of the 3 percent funds has steadily increased in each program year, from 47.2 percent in program year 1984 to 69.8 percent in program year 1988, and that if carry-over funds from previous years are subtracted, over 100 percent of the 3 percent funds are currently being spent.

The need for services provided under JTPA is underscored by a 1988 DOL study of displaced workers. According to the study, 4.7 million workers lost their jobs due to the decline of an industry or a plant closing between 1983 and 1988. The chance of reemployment for these displaced workers declined significantly with age. Only 51 percent of those workers between 55 and 64 were able to reenter the labor force in any capacity, as compared to 71 percent for those between the ages of 20 and 24. Only 30 percent of those over age 65 became reemployed. Of those who found a job, more than half (55 percent) received lower pay than at their previous job, and more than one-third took salary cuts of more than 20 percent. The study showed that the older an individual was when he or she lost a job, the longer he or she would be unemployed and the more likely he or she would become discouraged and drop out of the labor force altogether. Overall, there are more than 800,000 "discouraged" workers in the Nation.

(B) TITLE V OF THE OLDER AMERICANS ACT

The Senior Community Service Employment Program (SCSEP) was given statutory life under Title IX of the Older Americans Comprehensive Services Amendments of 1973. The program's stated purpose is "to promote useful part-time opportunities in community service activities for unemployed low income persons." SCSEP provides opportunities for part-time employment and income, serves as a source of labor for various community service activities, and assists unemployed older persons in their search to find permanent unsubsidized employment. Amendments passed in 1978 redesignated the program as Title V of the Older Americans Act, and it was reauthorized through fiscal year 1987 by the Older Americans Act Amendments of 1984. The Act was again reauthorized by the Congress in 1987 through fiscal year 1991. It will be reviewed for reauthorization during the first session of the 102d Congress.

The program is administered by the Department of Labor, which awards funds to national sponsoring organizations and to State agencies. Persons eligible under the program must be 55 years of age and older (with priority given to persons 60 years and older), unemployed, and have income levels of not more than 125 percent of the poverty level guidelines issued by the Department of Health and Human Services. Enrollees are paid the greater of the Federal or State minimum wage, or the local prevailing rate of pay for similar employment. Federal funds may be used to compensate participants for up to 1,300 hours of work per year, including orientation and training. Participants work an average of 20–25 hours per week. In addition to wages, enrollees receive physical examinations, personal and job-related counseling and, under certain circumstances, transportation for employment purposes. Participants may also receive training, which is usually on-the-job training and oriented toward teaching and upgrading job skills.

The SCSEP is one of the few direct job creation programs remaining since the elimination of the Comprehensive Employment and Training Act and the Public Service Employment programs. Nearly half of the enrollees are between the ages of 55 and 64, and more than a quarter are age 70 or older. About 70 percent are females, of whom half have not completed high school. Approximately 80 percent have a family income below the poverty line.

The SCSEP has seen steady increases in funding and participant enrollment since its inception. In the 1968–69 program year, the first full year of operation in a form similar to the current program, participant enrollment was 2,400 with a budget of $5.5 million. In program year July 1, 1990 to June 30, 1991, Title V funding appropriations are $367 million. The fiscal year 1990 appropriation represents a funding increase over fiscal year 1989. However, due mainly to an increase in the Federal minimum wage, the result is a decrease in employment positions supported by the program from 65,800 to 64,933. The increase in the minimum wage will raise the cost of each participant in the program from $5,225 in program year 1989 to $5,652 in program year 1990 and $6,061 in program year 1991. Although much of this additional cost has been compensated by an increase in Title V funding, budget constraints have prevented Congress from completely offsetting the effect of the minimum wage increase.

In recent years, the program has received generally positive reviews. In fiscal year 1986, a number of reports were issued that confirmed the general view that the program was successful and provided useful suggestions for improvements.

B. ISSUES AND CONGRESSIONAL RESPONSE

1. The Age Discrimination in Employment Act

(A) THE OLDER WORKERS BENEFIT PROTECTION ACT

The Older Workers Benefit Protection Act (P.L. 101-433), was signed into law by President Bush on October 16, 1990. Title I of this legislation was designed to overturn *Public Employees Retirement System of Ohio* v. *Betts*, 109 S.Ct. 2854 (1989), in which the Supreme Court held that the ADEA does not protect older workers from discrimination in the area of employee benefits. Title II placed new protections in the ADEA which should help to prevent abuses by some employers who ask employees to sign waivers of their ADEA rights.

Congressional concern over the *Betts* case resulted in the introduction of S. 1511, the Older Workers Benefit Protection Act, on August 3, 1989, by Senators Pryor, Jeffords, Metzenbaum, Kennedy, DeConcini, and Bumpers. The House companion, H.R. 3200, was introduced on August 4, 1989, by Congressmen Roybal, Hawkins, Clay, Martinez, and Bilbray. Senator Heinz introduced his own bill, S. 1293, parts of which were ultimately incorporated into the amended version of S. 1511 on the floor.

H.R. 3200 and the *Betts* decision were the subjects of a joint hearing of the House Select Committee on Aging and the House Education and Labor Subcommittees on Employment Opportunities and Labor-Management Relations on September 21, 1989. The Senate Special Committee on Aging and the Labor and Human Resources Subcommittee on Labor held a joint hearing on S. 1511 on September 27, 1989.

S. 1511 was favorably reported by the Senate Labor and Human Resources Committee on February 28, 1990. The Committee amended S. 1511 by attaching to it a modified version of S. 54, the Age Discrimination in Employment Waiver Protection Act of 1989. The Senate passed a compromise version of S. 1511 by a 94 to 1 vote on September 24, 1990. The compromise was passed in the House by a 406 to 14 vote on October 3, 1990.

(1) Protection of the Employee Benefits of Older Workers

June Betts was a public employee in Ohio. At age 61 she became permanently and seriously disabled and had no choice but to retire. Ohio's Public Employee Retirement System (PERS), as enacted in 1933, provided for basic retirement and disability retirement. Disability retirement, however, is limited to employees under 60.

In 1976, PERS was amended to provide that disability retirement payments could never be less than 30 percent of the retiree's salary. Under basic retirement Betts would have received $158.50 per month in benefits, and under disability retirement she would have received $355.00 per month. Betts was not allowed to take disability retirement because whe was over 60, and she was forced to settle for basic retirement benefits. She filed suit in Federal court contending that the PERS plan discriminated against older workers in violation of the ADEA.

Until the Supreme Court handed down its decision in June Betts' case, it had been widely accepted for 20 years that the ADEA protected older workers from discrimination in employee benefits.

In 1967, when the Senate was considering the bill that would become the ADEA, then Senator Javits offered an amendment with the goal of insuring that employers would not be discouraged from hiring older workers due to the fact that the cost of some benefits increases with age. This amendment, which would become section 4(f)(2) of the ADEA, created an exception from the proscriptions of the ADEA for a bona fide employee benefit plan "which is not a subterfuge to evade the purposes of [the Act] * * *." 29 U.S.C. section 623(f)(2).

The DOL issued a three paragraph regulation interpreting section 4(f)(2) in 1969. This regulation stated that "[a] retirement, pension or insurance plan will be considered in compliance with the statute where the actual amount of payment made, or cost incurred, in behalf of an older workers is equal to that made or incurred in behalf of a younger worker, even though the older worker may thereby receive a lesser amount of pension or retirement benefits, or insurance coverage." 29 C.F.R. section 860.120 (1969). This "equal benefit or equal cost" standard became the test for an employee benefit plan's compliance with the ADEA.

In 1977, the U.S. Supreme Court decided *United Airlines, Inc.* v. *McMann*, 434 U.S. 192 (1977), in which a retirement plan was forcing the early retirement of older workers. The Court held that the term "subterfuge," as used in section 4(f)(2), has a plain meaning (a scheme, plan, stratagem, or artifice of evasion), and by definition an employee benefit plan adopted prior to the enactement of the ADEA in 1967 could never be a "subterfuge." The Court therefore ruled that this retirement plan fell within the section 4(f)(2) exception and did not violate the ADEA.

In 1978, Congress reacted to the *McMann* decision by amending section 4(f)(2) with the phrase "no such * * * employee benefit plan shall require or permit the involuntary retirement of any individual [protected by this Act] because of age of such individual[.]" 29 U.S.C. section 623(f)(2). Congress also called on the DOL to further clarify its ADEA regulations.

During the Senate debate over the 1978 amendments to the ADEA, Senator Javits essentially endorsed the DOL's interpretation of section 4(f)(2) by clarifying what he had intended with his 1967 amendment:

> The purpose of section 4(f)(2) is to take account of the increased cost of providing certain benefits to older workers as compared to younger workers.
>
> Welfare benefit levels for older workers may be reduced only to the extent necessary to achieve approximate equivalency in contributions for older and younger workers. Thus a retirement, pension or insurance plan will be considered in compliance with the statute where the actual amount of payment made, or cost incurred in behalf of an older workers is equal to that made or incurred in behalf of a younger worker, even though the older worker may thereby receive a lesser amount of pension or retirement benefits, or insurance coverage.

In response to the congressional request, the DOL issued a more comprehensive version of the 1969 regulation. This expanded version was ultimately adopted by the EEOC when it took over enforcement of the ADEA in 1979. In its regulations the EEOC concluded that "[t]he legislative history of this provision indicates that its purpose is to permit age-based reductions in employee benefit plans where such reductions are justified by significant cost consideration." 29 CFR § 1625.10(a)(1). The EEOC then adopted the same equal benefit or equal cost interpretation contained in the 1969 Department of Labor regulation and used by Senator Javits in the 1978 floor debate.

Believing that the actions of PERS of Ohio violated the ADEA, Mrs. Betts' family filed a lawsuit on her behalf. Using the EEOC's equal benefit or equal cost test, the district court held in favor of Betts, finding that PERS did not qualify for the section 4(f)(2) exception to the ADEA. The U.S. Court of Appeals for the Sixth Circuit affirmed the district court's decision.

To the surprise and dismay of the Betts family and aging advocacy groups, the Supreme Court reversed the decision of the lower court. In the words of Justice Marshall, the *Betts* decision "immunize[d] virtually all employee benefit programs from liability under the Age Discrimination in Employment Act [(ADEA)] * * *."

In spite of a friend of the court brief submitted by the administration in support of the EEOC's regulation, the Supreme Court rejected this long-standing interpretation of the section 4(f)(2) exception, and instead adopted a "plain meaning" approach to the term "subterfuge." In doing so, the Court first reaffirmed its 1977 ruling in *McMann* that an employee benefit plan adopted prior to the enactment of the ADEA in 1967 could not be a subterfuge to evade the purposes of the Act. In other words, discriminatory pre-ADEA benfit plans can never be found to be unlawful under the ADEA. However, since PERS was amended in 1976, the Court could not dispose of the case on that basis.

Next, the Court held that a post-ADEA employee benefit plan does not violate the ADEA "so long as the plan is not a method of discriminating in other, nonfringe-benefit aspects of the employment relationship * * *." In other words, it is not a violation of the ADEA for an employer to discriminate against an older worker in terms of employee benefits as long as the benefit plan is not a vehicle for discrimination in other prohibited ways, such as salary, hiring or firing. Further, the Court held that an employee challenging an employee benefit plan under the ADEA has the burden of proving that the plan discriminates in some nonbenefit way. Based on these holdings, the Court reversed the lower court decision.

Advocates of elderly workers were very concerned about the large loophole left in the ADEA by the *Betts* decision. In addition, the EEOC was concerned because it had over 30 cases pending which faced dismissal based on the Supreme Court's decision. The business community contended that the equal benefit or equal cost regulation was not widely accepted and that the law in this area was anything but settled prior the Court's decision. A number of large employers and business associations believed that *Betts* was correctly decided and should be allowed to stand.

Significant concerns over S. 1151 as reported were expressed in four areas: retroactive application of the bill; application of the equal benefit or equal cost rule to early retirement incentive plans; integration of pension and severance benefits; and integration of pension and disability benefits. Each of these concerns were addressed in the final compromise version of the *Betts* provisions, and guidance on some of these issues was provided in the Statement of Managers, included in the Congressional Record at the time of passage. *See* 136 C.R. S13596 (101st Cong., Sept. 24, 1990).

Title I of the older Workers Benefit Protection Act amended section 4(f)(2) by deleting the term "subterfuge" and codifying the EEOC's long-accepted equal benefit or equal cost test for all employee benefits, with one notable exception. Early retirement incentive plans instead are required to be voluntary and consistent with the relevant purpose or purposes of the ADEA.

In addition, safe harbor exceptions from ADEA coverage are included for two particular types of early retirement incentives, subsidized early retirement benefits and Social Security bridge payments. While the practice of denying severance pay to pension-eligible employees continues to be a violation of the ADEA, Title I does allow an employer to offset severance pay against any retiree health benefits or lay-off triggered pension sweeteners received by an employee.

Further, Title I allows an employer to offset any pension benefits that an employee has voluntarily elected to receive, or, if the employee has reached normal retirement age, any pension benefits the employee is eligible to receive, against disability benefits to which the employee is entitled. This eliminates any possibility of an employer being forced to make duplicate payments of benefits. Other sections of Title I clarify that pre-1967 employee benefit plans are subject to the provisions of the ADEA, and that the 4(f)(2) exclusion is an affirmative defense under the ADEA which the employer must prove.

The retroactive application of the *Betts* provisions, included in earlier versions of S. 1511, was eliminated in the final compromise version. The general effective date for this title is 180 days following the date of enactment. Collectively bargained benefit plans have a delayed effective date until the expiration of the collective bargaining agreement or June 1, 1992, whichever occurs first. State and local public employee plans have a delayed effective date until 2 years following the date of enactment.

(2) Waivers of Rights Under the ADEA

Although certain substantive sections of the ADEA were taken from Title VII of the Civil Rights Act, Congress was careful to incorporate into section 7 of the ADEA the higher level of protection afforded by the Fair Labor Standards Act of 1938 (FLSA). The Supreme Court noted the incorporation of FLSA enforcement procedures into the ADEA in its decision in *Lorillard* v. *Pons,* 434 U.S. 575 (1978), stating that "[the] selectivity that Congress exhibited in incorporating provisions and in modifying certain FLSA practices strongly suggests that but for those changes Congress expressly made, it intended to incorporate fully the remedies and procedures of the FLSA."

Under the pre-ADEA case law dealing with contractual waivers of private rights under the FLSA, there were two Supreme Court cases which, taken together, may be interpreted to hold that FLSA rights cannot be privately waived. See *Brooklyn Savings Bank* v. *O'Neil,* 324 U.S. 697 (1945), and *Schulte, Inc.* v. *Gangi,* 328 U.S. 108 (1946). It would follow, then, that under the ADEA enforcement scheme nonsupervised private agreements to waive ADEA rights would also be impermissible.

In *Runyan* v. *National Cash Register Corp.,* 787 F.2d 1039 (6th Cir. 1986), however, a private release form purporting to waive all claims against an employer was held by the U.S. Court of Appeals for the Sixth Circuit to be binding under the ADEA. By a vote of 11 to 2, the court rejected the argument that an unsupervised private release of rights under ADEA is void as a matter of law. The court's holding was limited to the circumstances of the case where nothing indicated that the employer had exploited its superior bargaining power by forcing the employee had exploited its superior bargaining power by forcing the employee to accept an unfair settlement.

Many who believed that waivers were not permitted under the ADEA were highly critical of the *Runyan* decision's overall applicability to the ADEA. The plaintiff in the case was an experienced labor attorney and, therefore, extremely knowledgeable of the law. This prompted, arguments that *Runyan* was more the exception than the rule. Indeed, according to a 1981 Louis Harris survey conducted for the National Council on the Aging, over half the workers age 40 to 70 (those protected by the ADEA as of 1981) were unaware of the protections afforded them under the ADEA. Waiver opponents argued that, given this fact, it would be extremely difficult for most workers to execute knowing and voluntary waivers.

In the past, the EEOC recognized that application of the FLSA enforcement provisions to the ADEA could be interpreted to mean that individuals could not waive their rights or release potential liability, even if the action is voluntary and knowing, except under EEOC supervision. On October 7, 1985, however, EEOC published in the Federal Register a Notice of Proposed Rulemaking to allow for non-EEOC supervised waivers and releases of private rights under the ADEA. Nearly 2 years later, on July 30, 1987, the EEOC approved a final rule to permit unsupervised waivers.

The exemption allowed employers and employees to issue private agreements which contain waivers and/or releases of private rights under the ADEA without the supervision or approval of the EEOC. The Commission argued that the remedial purposes of the Act would be better served by allowing agreements to resolve claims whenever employees and employers perceive them to serve their mutual interests, provided such waivers of rights are knowing and voluntary. To support this view, the commission cited the similarities between the ADEA and Title VII of the Civil Rights Act of 1964, and noted that under Title VII, such unsupervised waivers of private rights are permissible.

However, in *Lorillard,* while the Court acknowledged that many of the ADEA's prohibitions were modeled after Title VII, it found significant differences in the remedial and procedural provisions of the two laws. The Court stated that "rather than adopting the procedures of Title VII for ADEA actions, Congress rejected that course in favor of incorporating the FLSA procedures even while adopting Title VII's substantive prohibitions . . . [The] petitioner's reliance on Title VII, therefore, is misplaced."

In justifying its regulation, the EEOC heavily relied upon the *Runyan* case. Opponents of the rule, however, noted the limited scope of the *Runyan* decision and argued that such a narrow decision did not justify the EEOC's decision to grant blanket waivers of individuals' ADEA rights without Government supervision. Waiver opponents also cited the filing of a strong dissent in the case and noted that EEOC's proposed regulation was cited in the final *Runyan* decision. Therefore, they argued, EEOC's heavy reliance on the circuit court's ruling was somewhat misplaced.

In short order, the EEOC rule became the focal point of controversy, with a number of older worker advocacy organizations and Members of Congress strongly opposing the EEOC's action. Although the EEOC claimed that the rule was in the best interest of the older worker, the Congress did not agree and enacted legislation to suspend the effect of the rule in fiscal years 1988, 1989, and 1990.

Following a September 1987 hearing of the Senate Special Committee on Aging, legislation to suspend the rule during the 1988 fiscal year was enacted in the fiscal year 1988 Continuing Resolution (P.L. 100-202). Nevertheless, at a May 24, 1988, hearing of the Senate Labor and Human Resources Subcommittee on Labor, a representative of the EEOC continued to defend the rule.

To provide sufficient time to develop a bipartisan policy in this area, legislation to extend the suspension through fiscal year 1989 was included in the fiscal year 1989 Commerce, Justice, State appropriation legislation (P.L. 100-459). Close to the end of the 100th Congress, S. 2856, the proposed "Age Discrimination in Employment Waiver Protection Act" was introduced, with the backing of major seniors groups, to resolve the issues surrounding unsupervised waivers. Except in the settlement of a bona fide age discrimination claim, the legislation would have barred unsupervised waivers of older workers' rights. Congress failed to act on this bill before the end of the 100th Congress.

S. 54, the "Age Discrimination in Employment Waiver Protection Act of 1989," was introduced by Senators Metzenbaum, Heinz, Pryor, and others early in the 101st Congress, and the suspension of the EEOC's waiver rule was extended through fiscal year 1990 by the fiscal year 1990 Commerce, Justice, State appropriations legislation (P.L. 101-162).

A modified version of S. 54 was added to S. 1511 during markup in the Senate Labor and Human Resources Committee. Title II of the Older Workers Benefit Protection Act does not contain any requirement of Federal supervision for ADEA waivers. Instead, it contains requirements which will insure that employees who are asked to sign waivers in exchange for enhanced benefits will have sufficient information and time to consider the offer.

The waiver must: (1) Be written in understandable language; (2) inform the employee of his/her rights under the ADEA; (3) not include rights or claims arising after the waiver is executed; and (4) be only in exchange for benefits in addition to those to which the employee is already entitled. In addition, the employee must be advised in writing to consult an attorney, and must be given 21 days in the case of an individual offering and 45 days in the case of a group offering in which to consider signing. Some further information is required in the case of group offerings.

The effective date for Title II was the date of enactment. Also, the EEOC's rule on waivers was invalidated on the date the bill became law.

(B) THE AGE DISCRIMINATION CLAIMS ASSISTANCE AMENDMENTS

The EEOC's continuing failure to process ADEA claims in a timely manner was once again an important issue during the 101st Congress. Following the discovery that between 1984 an 1988 more than 8,000 ADEA charges may have exceeded the 2-year statute of limitations due to the EEOC's neglect, Congress passed the Age Discrimination Claims Assistance Act of 1988 (ADCAA) (P.L. 100-283). ADCAA extended for 18 months the statute of limitations on those claims that had lapsed prior to the date of enactment through no fault of the claimant.

On February 6, 1990, the Senate Judiciary Committee held a confirmation hearing on the nomination of then EEOC Chairman Clarence Thomas to be a U.S. Circuit Judge. At that hearing it was revealed that the EEOC had allowed an additional 1,500 ADEA charges, most of which had been contracted out of State fair employment practice agencies (FEPAs), to lapse since 1988. An October 5, 1990, GAO report, requested by the House Select Committee on Aging, Committee on Education and Labor, and Subcommittee on Employment Opportunities, concluded that 2,801 charges had lapsed since ADCAA was enacted.

The "Age Discrimination Claims Assistance Amendments of 1990" (ADCAA II) (P.L. 101-504), sponsored by Congressman Roybal and others, extended by 15 months the statute of limitations on ADEA charges that lapsed due to EEOC neglect after the enactment of ADCAA but prior to the date that is 6 months after the enactment of the amendments. ADCAA II was signed into law by President Bush on November 3, 1990.

(C) TENURED FACULTY EXEMPTION

Provisions in the 1986 amendments to the ADEA to temporarily exempt universities from the law reflect the continuing debate over the fairness of the tenure system in institutions of higher education. During consideration of the 1986 amendments, several legislative proposals were made to eliminate mandatory retirement of tenured faculty, but ultimately a compromise allowing for a temporary exemption was enacted into law.

The exemption allows institutions of higher education to set a mandatory retirement age of 70 years for persons serving under tenure at institutions of higher education. This provision is in effect for 7 years, until December 31, 1993. The law also requires the EEOC to enter into an agreement with the National Academy of Sciences to conduct a study to analyze the potential consequences of the elimination of mandatory retirement for institutions of higher education. The study findings are to be submitted to the President and to Congress within 5 years of enactment. The law sets forth the composition of the study panel to include administrators and teachers or retired teachers at institutions of higher education.

Most agree that the tenure system is different from many other employment situations. Tenure protests academic freedom by prohibiting dismissals except under specific conditions. Many have argued that without mandatory retirement at age 70, institutions of higher education will not be able to continue to bring in those with fresh ideas. The older faculty, it is claimed, would prohibit the institution from hiring younger teachers who, with their current state of knowledge, are better equipped to serve the needs of the school. The argument also is made that allowing older faculty to teach or research past the age of 70 denies women and minorities access to the limited number of faculty positions.

Opponents of the exemption claim that there is little statistical proof that older faculty keep minorities and women from acquiring faculty positions. Indeed, they cite statistical information gathered at Stanford University and analyzed in a paper by Allen Calvin which suggests that even with mandatory retirement and initiatives to hire more minorities and women, there was only a slight change in the percentage of tenured minority and women faculty.

Proponents of an exemption cite a study by the Labor Department that the salaries of faculty nearing retirement are about twice those of newly hired faculty. Accordingly, they argue that prohibiting mandatory retirement might also exacerbate the financial problems many colleges and universities are facing.

Those who oppose the exemption believe that there are not sufficient reasons to single out faculty for special, discriminatory treatment. They call it double discrimination—once on the basis of age and again on the basis of occupation—and argue that colleges and universities are using mandatory retirement to rid themselves of both undesirable and unproductive professors, instead of dealing directly with a problem that can afflict faculty members of any age. The use of performance appraisals, they argue, is a more reliable and fair method of ending ineffectual teaching service than are age-based employment policies. Finally, they claim that there is no evidence that many professors would stay past age 70 even if they could, and that predictions of dire consequences from uncapping the retirement age may be exaggerated. According to the Teachers Insurance Annuity Association and College Retirement Equities Fund, the average age at which faculty members begin collecting their pensions—which usually represents a retirement date—has been declining over the past 10 years.

(D) STATE AND LOCAL PUBLIC SAFETY OFFICER PROVISION

As previously noted, the ADEA allows a defense to a charge of age discrimination in the workplace where "age is a bona fide occupational qualification (BFOQ) reasonably necessary to the normal operation of a particular business, or where the differentiation is based on reasonable factors other than age." The BFOQ defense has been most successful in cases that involve the public safety. Some courts have allowed maximum hiring ages and mandatory retirement ages for bus drivers and airline pilots, and, on occasion, police officers and firefighters because the safety of the public was at stake. The courts, however, have been inconsistent and the lack of clear judicial guidance has prompted calls for reform.

The issue of whether public safety officers should be treated like other employees under the ADEA arose after the Supreme Court, in *EEOC* v. *Wyoming,* 460 U.S. 226 (1983), determined that the State's game wardens were covered by the ADEA. Wyoming's policy of mandatory retirement at age 55 for State game wardens was ruled invalid unless the State could show that age is a BFOQ for game wardens. Wyoming had not attempted to establish a BFOQ in this case, but had instead argued that application of the ADEA to the State was precluded by constraints imposed by the 10th amendment on Congress' commerce powers—an argument not sustained by the Court.

In addition, in June 1985, the Supreme Court rendered two decisions in cases arising under the ADEA favorable to employees who had challenged the mandatory retirement policies of their employers. The first case, *Johnson* v. *Mayor and City Council of Baltimore,* 472 U.S. 353 (1985), involved six firefighters who challenged the City of Baltimore's municipal code provision that established a mandatory retirement age at 55 for firefighters. The Court of Appeals, accepting the city's argument, had held that the Federal civil service statute, which requires most Federal firefighters to retire at age 55, constituted a BFOQ for the position of firefighters employed by the city. The Supreme Court reversed this decision, stating that nothing in the *Wyoming* decision or the ADEA warrants the conclusion that a Federal rule, not found in the ADEA, and by its terms applicable only to Federal employees, necessarily authorizes a State or local government to maintain a mandatory retirement age as a matter of law.

The Court found that it was Congress' indisputable intent to permit deviations from the mandate of the ADEA only in light of a particularized, factual showing. The Court concluded that Congress' decision to retire certain Federal employees at an early age was not based on a BFOQ, but instead dealt with "idiosyncratic" problems of Federal employees in the Federal civil service. Accordingly, the Court ruled that a State or private employer cannot look to exemptions under Federal law as dispositive of BFOQ exemptions under the ADEA. There is a need, the Court said, to consider the actual tasks of the employees and the circumstances of employment to determine when to impose a mandatory retirement age.

The second case, *Western Airlines, Inc.* v. *Criswell,* 472 U.S. 400 (1985), raised a challenge under the ADEA to Western Airline's requirement that flight engineers, who do not operate flight controls as part of the cockpit's crew unless the pilot and co-pilot become incapacitated, were subject to mandatory retirement at age 60. The Supreme Court upheld a jury verdict for the plaintiffs against an airline defense that the age 60 requirement constituted a BFOQ. The Court confirmed that the BFOQ defense is available only if it is reasonably necessary to the normal operation or essence of a defendant's business. The Court also noted that an employer could establish this defense only by proving that substantially all persons over an age limit would be unable to perform safely and efficiently the duties of the job, or that it would be impossible or highly impractical to deal with older employees on an individualized basis.

In both of these cases, a unanimous Court seemed to be looking very critically upon attempts to expand the BFOQ defense beyond specific high risk occupations. The Court also stressed the relationship between individual performance and employment in a particular task, rather than reliance on a standard of chronological age disqualification. Thus, by adopting a very narrow reading of the BFOQ exemption, the Court appeared to have strongly endorsed individualized determinations.

However, many States and localities with mandatory retirement age policies below age 70 for public safety officers were concerned about the impact of these decisions. As of March 1986, 33 States or localities had been or were being sued by the EEOC for the establishment of mandatory retirement or minimum hiring age laws. In response, a temporary exemption from the law was provided for State and local public safety officers in the 1986 amendments to the ADEA. The provision is in effect for 7 years, until December 31, 1993.

The 1986 amendments also required the Secretary of the Department of Labor and the EEOC to conduct a study and to report to Congress on whether physical and mental fitness tests can be used as a valid measure to determine the competency of police officers and firefighters and to develop recommendations on standards that such tests should satisfy. The study is to be submitted to Congress within 4 years of enactment of the law. The law also requires that within 5 years of enactment, the EEOC propose guidelines for the administration and use of physical and mental fitness tests to measure the ability and competency of police and firefighters to perform their jobs.

Supporters of a permanent exemption for State and local public safety officers argue that the mental and physical demands and safety consideration for the public, the individual, and co-workers who depend on each other in emergency situations, warrant mandatory retirement ages below 70 for these State and local workers. Also, they contend that it would be difficult to establish that a lower mandatory retirement age for public safety officers is a

BFOQ under the ADEA. Because of the conflicting case law on BFOQ, this would entail costly and time consuming litigation. They note that jurisdictions wishing to retain the hiring and retirement standards that they established for public safety officers prior to the *Wyoming* decision are forced to engage in costly medical studies to support their standards. Finally, they question the feasibility of individual employee evaluations, some citing the difficulty involved in administering the tests because of technological limitations concerning what human characteristics can be reliably evaluated, the equivocal nature of test results, and economic costs. They do not believe that individualized testing is a safe and reliable substitute for pre-established age limits for public safety officers.

Those who oppose an exemption contend that there is no justification for applying one standard to Federal public safety personnel and another to State and local public safety personnel. They believe that exempting State and local governments from the hiring and retirement provisions of the ADEA in their employment of public safety officers will give them the same flexibility that Congress granted to Federal agencies that employ law enforcement officers and firefighters.

As an additional argument against exempting safety officers from the ADEA, opponents note that age affects each individual differently. They note that tests can be used to measure the effects of age on individuals, including tests that measure general fitness, cardiovascular condition, and reaction time. In addition, they cite research on the performance of older law enforcement officers and firefighters which supports the conclusion that job performance does not invariably decline with age and shows that there are accurate and economical ways to test physical fitness and predict levels of performance for public safety occupations. All that the ADEA requires, they argue, is that the employer make individualized assessments where it is possible and practical to do so. The only fair way to determine who is physically qualified to perform police and fire work is to test ability and fitness.

Lastly, those arguing against an exemption state that mandatory retirement and hiring age limits for public safety officers are repugnant to the letter and spirit of the ADEA, which was enacted to promote employment of older persons based on their ability rather than age and to prohibit arbitrary age discrimination in employment. They believe that it was Congress' intention that age should not be used as the principal determinant of an individual's ability to perform a job, but that this determination, to the greatest extent feasible, should be made on an individual basis. Maximum hiring age limitations and mandatory retirement ages, they contend, are based on notions of age-based incapacity and would represent a significant step backward for the rights of older Americans.

For jobs that can affect the public safety but that are not State or local public safety officer occupations, there currently is no blanket exemption from the ADEA. BFOQ remains as the most common defense used by employers who place mandatory age limits on such positions.

In the case of *Tullis* v. *Lear School, Inc.*, 874 F.2d 1489 (11th Cir. 1989), the court found that Lear School, a private school in Dade County, FL, was in violation of the ADEA when it terminated a school bus driver who had reached the age of 65. The court disallowed the BFOQ defense because the school failed to prove that as a group, all or most school bus drivers over the age of 65 are unable to perform their jobs safely, and the school failed to show that it was not feasible to conduct individualized assessments of its bus drivers' medical qualifications.

(E) APPRENTICESHIP PROGRAMS

According to EEOC's current interpretation, apprenticeship programs are exempt from the proscriptions of the ADEA. This exemption, in effect, permits employers and labor unions to exclude men and women over age 40 from entering these programs solely because of their age.

The current interpretation has been in effect since 1969, when the DOL published interpretive guidelines which provided that apprenticeship programs are not subject to the requirements of the ADEA. Since then, the DOL has viewed the elimination of the exemption as detrimental to the promotion of such programs in the private sector since they are widely seen as a training program for youth in which the initial investment and training can be recouped over the apprentice's worklife. However, others contend that to exclude older workers from participation in bona fide apprenticeship programs is to deny them needed retraining opportunities. They argue that rapid technological changes often make the skills of older workers obsolete.

Upon receiving responsibility for upholding the ADEA in 1979, the EEOC began to explore the possibility of amending the old DOL interpretation. However, attempts to do so were unsuccessful. Subsequently, a 1983 decision in *Quinn* v. *New York State Electric and Gas Corporation,* 569 F. Supp. 655 (1983), held that neither the language of the ADEA nor its legislative history support a conclusion that Congress intended to exempt apprenticeship programs from the ADEA. Following this decision, the EEOC decided to reconsider the exemption. On June 13, 1984, the Commission unanimously voted to rescind the current exemption and issued proposed regulations which would prohibit arbitrary age discrimination in such programs. The regulations, however, languished before the Office of Management and Budget, apparently because the DOL has opposed the proposed change.

Finally, on July 30, 1987, the Commission reversed itself and voted against changing the old interpretation. According to EEOC Chairman Clarence Thomas, any decision to change that position would be "properly left for the Congress." This was the same day the Commission cited its broad authority to promulgate regulations in passing its rule (discussed below) permitting employees to waive their ADEA rights without EEOC supervision. By retaining the old DOL interpretation, EEOC has effectively precluded midlife and older workers seeking critical new job skills from receiving needed training through these programs.

(F) APPOINTED STATE JUDGES

Section 11(f) of the ADEA defines the term "employee," and specifically excludes "any person elected to public office in any State or political subdivision * * * or an appointee on the policymaking level * * *." 29 U.S.C. section 630(f). Recently, a number of court cases have raised the question whether an appointed State judge is excluded from the protections of the ADEA as "an appointee on the policymaking level."

In *Schlitz* v. *Virginia,* 681 F. Supp. 330 (E.D. Va. 1988), the court was considering an appointed State judge's challenge under the ADEA of Virginia's mandatory retirement of judges who reach the age of 70. The court stated that appointed State judges have all the characteristics of employees of the State, and absent some specific exclusion in the Act, they are covered by the ADEA. After noting that the distinction that the Congress chose to make in section 11(f) was between elected and appointed State officials, the court held that appointed State judges were entitled to the protections of the ADEA and could not be forced to retire because of age.

The U.S. Court of Appeals for the First Circuit applied different reasoning in *EEOC* v. *Massachusetts,* 858 F.2d 52 (1st Cir. 1988). Here the court found the elected versus appointed analysis unpersuasive. Instead, it reasoned that while appointed State judges are not "policymakers" in the same sense as executive or legislative appointees, they are necessarily policymakers as a function of judging. The court therefore held that appointed State judges fall within the "appointee on the policymaking level" exception and are not covered by the ADEA.

In *EEOC* v. *Vermont,* 717 F. Supp. 261 (D. Vt. 1989), the court strongly disagreed with the First Circuit's conclusion that appointed State judges are policymakers. "A judge's principal activity is to decide cases between litigants involving questions of law in which there are no interstices or lacunae to fill. In any event, gap-filling by judges is really a form of lawmaking, not policymaking." 717 F. Supp. at 264–265. The court found that appointed State judges do not fall within any of the section 11(f) exceptions, and it held that Vermont Supreme Court Justice Louis Peck is protected by the ADEA and cannot be forced to retire due to age.

Most recently, the U.S. Court of Appeals for the Eighth Circuit addressed this issue in *Gregory* v. *Ashcroft,* 898 F.2d 598 (8th Cir. 1990). In affirming the decision of the district court that Missouri's appointed State judges are exempt from the protections of the ADEA, the court adopted the reasoning of the First Circuit. " '[Policymaking]' is indisputably a part of the function of judging to the extent that judging involves lawmaking to fill the interstices of authority found in constitutions, statutes and precedents." (*Gregory,* 898 F.2d at 601 (*quoting Massachusetts,* 858 F.2d at 55).) In addition, in considering the judges' arguments in favor of ADEA coverage, the court found an anomaly in the possibility that Missouri, which has both elected and appointed judges, would have some judges covered and some judges exempted from coverage.

The Supreme Court has agreed to hear *Gregory* and will soon resolve the question whether appointed State judges are entitled to the protections of the ADEA.

(G) PENSION ACCRUAL PROVISIONS

In May 1979, the DOL published an interpretive bulletin regarding the 1978 ADEA amendments. The interpretation allowed employers with pension plans regulated under the Employee Retirement Income Security Act (ERISA) to cease pension contributions and pension credits for active employees who worked beyond the normal retirement age specified in their pension and retirement plans.

The EEOC, which assumed enforcement responsibility of the ADEA shortly after, initiated a review of its pension accrual policy in 1983. After evaluating hundreds of comments from individuals and groups, the majority of whom opposed the interpretive bulletin, EEOC commissioners in 1984 voted to rescind the bulletin and to require employers to continue to post credits to the pensions of workers beyond the normal retirement age. Subsequently, proposed regulations were drafted by the EEOC mandating continued pension accrual, which the Commission in 1985 unanimously approved.

Poised to implement the new policy regarding pension accrual for workers over age 65, the EEOC in 1986 instead reversed directions, abandoning all rulemaking on continued pension accrual and refusing to rescind the bulletin. Although the EEOC also was ordered by the court to issue a new rule governing continued pension accrual, this portion of the ruling was reversed upon appeal.

After extended debate on this issue, provisions were included in the 1986 ADEA amendments to require employers to continue accrual of pension credits to workers beyond the normal retirement age, effective January 1988. More specifically, the law required pension coverage for all workers without regard to age, excepting (1) defined benefit plans that increase the worker's retirement actuarially to reflect a benefit date that occurs after the month in which the worker turns 65, and (2) plans which limit the amount of benefits or limit the number of years of service or years of participation. Under Public Law 99-509, the Internal Revenue Service (IRS), followed by the EEOC and the DOL, were required to develop regulations in accordance with the new law.

Unfortunately, the new law was vague as to whether the new law was intended to be applied on a retroactive basis. Initially, the EEOC contended that the law did not require employers to take post credits for older workers for years served prior to the law's effective date, a position that was estimated to cost older workers $3 billion in lost pension benefits.

However, a complex rule proposed in April 1988 by the IRS, the lead agency, provides that in defined benefit plans—namely, plans which promise a retired worker a set pension based on number of years of employment and a percentage of compensation—all years of service must be taken into account in determining retirement benefits. In contrast, with respect to defined contribution plans—those in which an employer pledges to allocate a certain percentage of compensation each year toward the worker's pension—the law would not be applied retroactively under the IRS ruling.

Thus, under the IRS rule, a worker with a defined benefit plan who turns age 65 prior to 1988 would accrue pension credits for years of service prior to the law's 1988 effective date. However, if the same worker was covered by a defined contribution plan, only employment after January 1988 would be credited. According to the IRS, until a final rule is issued, the proposed regulations are in effect. In early 1989, the EEOC backed away from its earlier opposition and intends to conform to the IRS position.

2. OUR AGING WORK FORCE

(A) DEPARTMENT OF LABOR STUDIES

In January 1989, the Department of Labor released two new reports on older workers and their impact on our Nation's labor market. These reports analyze current work force and labor market data, and make important and interesting projections for older workers for the future.

(1) Demographic Trends in the Work Force

Demographic trends in the work force are examined in a DOL report entitled "Older Worker Taskforce: Key Policy Issues for the Future." The report projects that by the year 2000, the median age of the labor force will increase from about 36 to 39. Also, by the year 2000, the report projects an increase in the number of workers age 55 and over and a decrease of almost 1 million in the number of workers age 16 to 24. These figures confirm that with the aging of the "baby boomers," the population from which our work force is drawn is also aging.

When these projections are combined with the report's additional projection that labor force participation among individuals age 55 and older will decrease significantly by the year 2000, the result is a potential labor shortage. The report concludes that it is important for the government and employers to remove institutional barriers that discourage older workers from continuing in or re-entering the work force. In addition, incentives to retain or attract older workers should be emphasized, and training should be provided to older workers as a means for enhancing and upgrading their skills.

(2) Barriers and Disincentives for Older Workers

As discussed above, there has been a decreasing trend in work force participation by older workers. The average age at which people begin to draw Social Security benefits is now 63. However, there is growing concern in some circles about the consequences of early retirement. Many contend that a large number of employees who leave the work force, either voluntarily or due to forced retirement, find themselves ill-prepared for the financial consequences. While many believe that retirees who left the work force too early in life are attempting to return, there is presently little proof.

The 1989 unemployment rates for workers in the age groups of 45 to 54, 55 to 64, and 65 and older were significantly lower than the unemployment rates for younger workers. Because an individual must be out of work and actively seeking employment in order to be counted as unemployed, there are at least two viable explanations for these differences. One explanation is encouraging and the other is not. First, the improved pension system may be making it possible for more workers to leave the labor force and permanently retire. Second, the frustration of older individuals in enduring much longer periods of unemployment than younger individuals may be forcing many of them to give up and leave the labor force.

Legislation was enacted on December 22, 1987 (P.L. 100-202) which requires a study of older persons who are attempting to re-enter the work force. The purpose of the study was to provide the Congress with a better understanding of the issues and obstacles facing older persons seeking to re-enter the workplace.

The DOL report is entitled "Labor Market Problems of Older Workers." The report reiterates long-standing problems facing older persons seeking employment, concluding that many older workers are pressured into early retirement and that "pension rules and job market realities severely limit their options and opportunities." The report also points out that a number of financial disincentives to re-entering the job market persist, including the low pay of part-time work and the Social Security earnings limitation. Looking ahead, the report states that the average retirement age, which had been on a downward trend, has stabilized or gone up slightly in recent years, and that there may be an increased demand for older workers as the general population continues to age. Ultimately, however, the report concludes that the state of the Nation's economy will determine the value accorded to older workers.

(B) HEALTH COSTS

While we have witnessed a steady decline in labor force participation by older people over the past several decades, concerted efforts are now being directed toward reversing this trend. "Worklife extension" is the term used to describe the move to extend the worklife of older persons willing and able to work. An important theme in the discussion of worklife extension is the health of the older population. Employers and policymakers are concerned about the health implications of extended worklife, especially as they relate to issues of labor supply, productivity, employee health costs, and health maintenance.

A February 1985 information paper entitled "Health and Extended Worklife," prepared by the Special Committee on Aging, presents information about the health status of older persons as related to extended work lives. The findings of the study indicate that the noninstitutionalized older population, and particularly the younger members of that population, are healthier than is widely believed. Health is one of several variables which affect the supply of workers, their level of productivity, and their utilization of health services. The data presented in this paper can be of assistance to the Congress and employers in making informed decisions about employment and retirement issues.

Conventional wisdom suggests that older workers are paid more than younger workers for the same job, and, therefore, are more expensive. This perception has frequently been used to support early retirement programs. There is, unfortunately, little empirical information to help discern whether it costs more to employ older workers. In September 1984, the Senate Aging Committee released an information paper which examines factors contributing to labor costs by age, and discusses direct compensation, employee benefits, turnover, training, performance, and productivity.

The evidence indicates that there are some types of employment costs that vary by age, and that overall compensation costs increase by age, largely because of increasing employee benefit costs. There is, however, no statistical evidence that direct salary costs on an economywide basis increase by age. Employee benefit costs are not usually separated by age, and individual employers do not generally make hiring and retention decisions on the basis of benefit costs. General increases in medical care costs, combined with an expanding set of laws and regulations, however, have focused the spotlight on employee benefit costs for older workers, and it is possible that employers will give more consideration to this issue in the future.

The belief that older workers cost more appears related to feelings about performance and productivity. There is no statistical evidence to link poorer performance or productivity with age, and the limited data available refutes the notion that older workers are less capable. However, there is a significant issue relating to maintenance of skills and training. Over time, as the nature of work and the skills required for a job change, if employees are not kept up to date, there will be an increasing deterioration of performance on that specific job. If older workers are to be cost effective, their skills must be continuously updated through training and education. The two major conclusions of the information paper are as follows:

> It is extremely important to encourage the maintenance of skills and lifelong education to prevent older worker obsolescence and to provide individuals with the skills needed to compete on a fair basis. Up-to-date skills are more important than any age-related capabilities in human resource cost and older worker productivity.
>
> Legislative and regulatory requirements affecting employment costs for older workers should not place undue costs or administrative burdens on employers. Such requirements can discourage the employment of older workers.

A 1989 report by the American Association of Retired Persons, entitled "Business and Older Workers," found that 71 percent of responding firms rated the extra cost of health insurance for employees age 50 and over to be significant when compared to total company health care costs. Only 16 percent of the employers questioned rated a 55-year-old employee as being extremely costly to insure, as compared to 22 percent for a 30-year-old with two dependents. However, 34 percent of firms said that health insurance for a 65-year-old retiree is very expensive.

The Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA), legislated changes in Medicare coverage for older workers. As of January 1983, employers could no longer advise workers that they were to be dropped from company group health insurance plans at age 65 because they were eligible for Medicare. TEFRA requires that company plans bear the primary burden of health costs, making Medicare the secondary insurer. The TEFRA requirement raised employer costs in two ways. First, costs rose for employees age 65 through 69 who previously were covered by employer plans, because these plans now are the primary payer of benefits. Second, employees age 65 through 69 who previously were excluded from employer health plans, were covered if the employer offers a plan to any of its employees.

Two major provisions in the Deficit Reduction Act of 1984 (DEFRA) also had an effect on the costs of employing older workers and on the costs to older workers of remaining employed longer. The first is section 2301 of DEFRA, which modified the working-aged provision—originally included in TEFRA—so that an employer must offer group health coverage to an employee who has not reached age 65 if the employee has a spouse age 65 through 69. If such an employee elects the group coverage—versus Medicare coverage for the spouse—the employer must offer the same coverage as that offered to employees with spouses under age 65. In such cases, Medicare would be the secondary payer, while the employer sponsored plan would be primary. The implications of this provision for employers are relatively minor when taken alone, but when added to the effects of already existing cost factors, they are significant. Now employers have yet another reason not to hire or retain older workers under age 65. If they have an older spouse, the employer, rather than Medicare, is required to pay the health costs for the spouse.

The second provision, section 2338 of DEFRA, removed a disincentive for older workers to remain on their employer's health plan. Under the TEFRA provision, employees who elected, after age 65, to remain in their employer's health plan would have been penalized for not enrolling in Part B of Medicare upon their 65th birthday. This penalty amounted to a 10-percent increase in annual premiums for each 12 months that the employee did not enroll after his or her 65th birthday. Since the Medicare coverage was duplicative of the employer plan, there was no need to enroll in Part B until after retirement—except for the stiff penalty imposed. DEFRA waived the Part B premium for workers and their spouses age 65 through 69 who elect private coverage under the provisions of TEFRA. It also established special enrollment periods for such workers. The waiver applies for the period during which an individual continues to be covered under an employer's group health plan.

The MSP cycle was completed in 1985, when a provision in the Consolidated Omnibus Budget Reconciliation Act (COBRA) removed the age 70 age limit on the Medicare secondary status of actively employed workers and their spouses. This gave employer group health insurance primary responsibility for all actively employed workers and their spouses, regardless of age. Since that time, although some minor legislative changes have been made, efforts with respect to MSP have focused on problems with the compliance of Medicare contractors, insurers, employers, and providers with the program. For a more detailed discussion of this issue, please see the relevant section of the Health Chapter.

Finally, employer's health care insurance obligations to older employees under the ADEA were expanded by the fiscal year 1986 budget reconciliation legislation (P.L. 99-272). The law removed the upper age limit of 69 and employers are now required to offer employees and their spouses aged 69 and over the same group health insurance coverage provided to younger workers.

Another issue is the difficulty some employers—particularly those with few employees—are having in finding adequate health insurance coverage for their older workers. In 1983, the Wall Street Journal reported that insurance companies know that groups containing older people will run up bigger medical bills than those with younger participants. As a result, insurance premiums for the group plans have soared. Some insurance companies have gotten out of the small group business altogether because they have concluded these plans are nonprofitable. Higher insurance premiums for employers create another disincentive to hire and retain older workers.

Despite concerns among employers about the costs of older workers, the Federal Government is seeking ways of keeping older workers in the labor force. The most notable examples of this are the 1983 amendments to the Social Security Act. The compromises that resulted in the amendments (P.L. 98-21) reflect the belief in Congress that older people are healthier today and, therefore, can continue to work longer. The desired effect of the amendments is to provide older workers with a disincentive to leaving the labor force by increasing the penalty for early retirement, increasing the age at which full retirement benefits are paid, increasing the delayed-retirement credit, and reducing the penalty on earnings after retirement.

3. THE JOB TRAINING PARTNERSHIP ACT

During the 101st Congress, the Job Training Partnership Act was the subject of much discussion. While most agreed that JTPA has been effective since its enactment in 1983, the Department of Labor and several Members of Congress believed that adjustments to the Act were necessary to meet the changing needs of our Nation's work force.

In particular, much of the discussion centered on the idea of cutting back or eliminating State-level set-asides, including the Title II-A set-aside for training and placement of older workers, and concentrating more resources at the local level through the service delivery areas (SDAs). Supporters of this idea felt that more services were needed at the local level, and specifically more job training services were needed for inner-city youth.

Possible elimination of the Title II-A older worker set-aside caused concern among advocates for the elderly, who argued that youth are not the answer to future shortages in the work force. Then Secretary of Labor Elizabeth Dole recognized the importance of older workers when she stated in the October 1989 edition of *Aging News Network:*

> Experience, maturity, know-how, dependability—these and other positive traits that characterize older workers have always been important to any nation that wants to build and maintain a strong, competitive economy. But as we look to the dawn of a new century, they may be especially critical to our Nation's need to compete in today's global marketplace.

> All of this means that we can ill afford policies or practices that discourage skilled, experienced, productive men and women from continuing to work past retirement age if they want to do so.

Supporters of the Title II–A older worker provision contended that while programs funded by the set-aside generally started slowly in the first years, the vast majority of them are now very successful and should not be eliminated. Two bills received the most attention.

(A) THE SIMON BILL

On March 8, 1989, Senator Paul Simon introduced S. 543, the "Job Training Partnership Act Youth Employment Amendments of 1989." As introduced, the bill would have reallocated JTPA resources to provide more services to inner-city youth. In accomplishing this goal, the bill would have reduced the older worker set-aside from 3 percent to 2 percent.

An amended bill was reported by the Senate Labor and Human Resources Committee on July 26, 1989. The title was changed to the "Job Training and Basic Skills Act of 1989," and, in addition, the older worker set-aside was completely eliminated. In its place was a requirement that 5 percent of the adults served by the SDAs must be 55 years of age or older. Older worker advocates felt that this participant-based set-aside would not ensure service of sufficient types of amounts, and they contended that a dollar-based state-level set-aside is the best and only way to guarantee quality service for this age group.

A modified version of the Simon bill was attached in the Senate to the Labor-HHS Appropriations Conference Report, H.R. 5257, but was rejected by the House. This package of JTPA amendments contained important older worker provisions, including a dollar-based set-aside roughly equivalent to the 3 percent set-aside, that were requested by Senators Pryor, Grassley, and Heinz.

(B) THE HAWKINS BILL

Congressman Augustus F. Hawkins introduced H.R. 2039, the "Job Training Partnership Act Amendments of 1989," on April 18, 1989. Like S. 543, H.R. 2039 would have reallocated JTPA resources with an emphasis on serving inner-city youth. This bill would have completely eliminated the Title II–A older worker set-aside and replaced it with a mandate to the SDAs to make special efforts to serve adult workers 55 years of age or older.

The Hawkins bill was ordered reported favorably by the House Education and Labor Committee on July 31, 1990, and it was passed in the House by a vote of 416–1 on September 27, 1990. The Senate failed to act on this legislation.

C. PROGNOSIS

A variety of issues must be resolved in the years to come with respect to the employment of older and midlife workers. Further advances must be made in prohibiting age discrimination in employment, and an important question is how to solve permanently the EEOC's problems in processing ADEA claims in a timely fashion. With the input of private sector experts representing both the business and aging communities, the Special Committee on Aging has been exploring a number of options. Chairman Pryor and Ranking Minority Member Heinz will likely join in proposing legislation on this subject during the 102d Congress.

With the reauthorization of the Older Americans Act fast approaching, the Title V SCSEP program will be reviewed during the first session of the 102d Congress. Although the program has generally been very successful, some changes may be proposed.

Still another issue is whether to maintain JTPA's commitment to ensuring that disadvantaged older workers receive much needed job training and placement services. The Simon and Hawkins JTPA amendments seemed to abandon this commitment by lumping older workers, who have unique employment problems and needs, with younger adults. The House and Senate will almost certainly face this issue again in the 102d Congress.

Other issues include whether to extend ADEA protection to tenured university faculty, public safety officers, and older workers in apprenticeship programs. Although stereotypes abound regarding unproductive, fractious older employees, there is a growing realization that older workers are a very diverse group.

The phenomenon of an aging work force presents a variety of potential problems, especially when considered with the trend toward early retirement. In attempting to downsize their work force, many companies have chosen to absorb the cost of offering early retirement packages to their employees. However, there is growing concern that in so doing, many companies are merely considering short-term savings without regard to long-term costs due to lost experience, increased pension liabilities, and increased training costs.

As the Nation's population ages, there will be additional pressures to maintain an older work force. This will likely result in the eventual conclusion by the business community that it is to their advantage to modify their current employment practices and provide incentives for older workers to remain on the job. As this occurs, there may well be less need for Federal intervention to assure that older Americans are not victimized by age discrimination. However, until the advantages of employing and retaining older workers are widely acknowledged by business, it will remain essential that older persons who desire to work can rely on the EEOC to protect their rights under the ADEA.

Chapter 5

SUPPLEMENTAL SECURITY INCOME

OVERVIEW

In 1972, the Supplemental Security Income (SSI) program was established to help the Nation's poor aged, blind, and disabled meet their most basic needs. The program is designed to supplement the income of those who do not qualify for Social Security benefits or whose Social Security benefits are not adequate for subsistence. The program also provides recipients with opportunities for rehabilitation and incentives to seek employment. In 1990, 4.7 million individuals received assistance under the program.

To those who meet SSI's nationwide eligibility standards, the program provides monthly payments. In most States, SSI eligibility automatically qualifies recipients for Medicaid coverage and food stamp benefits.

Despite the budget cuts that many programs have suffered in the 1980's, SSI benefits have not been lowered. This is in part because under the Gramm-Rudman-Hollings Act, SSI benefit payments have been exempted from across-the-board budget cuts. It is also because of widespread support for the program, recognition of the subsistence-level benefit structure, and concern about the program's role as a safety net for the lowest-income Americans.

Although SSI has escaped the budget axe, the lack of funding for benefit increases has meant that the program continues to fall far short of eliminating poverty among the elderly poor. Despite progress in recent years in alleviating poverty, a substantial number remain poor. When the program was started almost two decades ago, some 14.6 percent of the Nation's elderly lived in poverty. In 1989, the elderly poverty rate was 11.4 percent.

The effectiveness of SSI in reducing poverty is hampered by inadequate benefit levels, stringent financial criteria, and a low participation rate. In most States, program benefits do not provide recipients with an income that meets the poverty threshold. Nor have the program's allowable income and assets level kept pace with inflation. Further, only about half of those poor enough to qualify for SSI actually receive program benefits.

In recent years, the gulf between SSI's reality and its potential as an anti-poverty weapon has given rise to a movement among advocates and a number of Members of Congress to try and correct the program's inadequacies. In the 101st Congress, these efforts produced legislative proposals to bring the benefit standard to the poverty level, increase the program's income and assets levels, and mandate SSI outreach. In addition, a number of other program reforms were proposed and a number of significant technical improvements of the SSI program were enacted. However, no major proposals to restructure the program were enacted, largely due to budget constraints.

Among the issues which provoked SSI reform legislation in 1990 was the lack of oversight of representative payees by the Social Security Administration (SSA), the agency charged with administering the SSI program. Following intense scrutiny by the Congress, comprehensive bills to strengthen investigation and monitoring of representative payees for this vulnerable population were enacted in 1990.

In 1990, Commissioner Gwendolyn S. King's first year as the new Commissioner of the agency, SSA maintained a bipartisan and accessible tone in its dealings with the Congress, and has taken steps to address problems in the SSI program. She established a task force which is exploring methods of improving the program.

A. BACKGROUND

The SSI program, authorized in 1972 by Title XVI of the Social Security Act (P.L. 92-603), began providing a nationally uniform guaranteed minimum income for qualifying elderly, disabled, and blind individuals 2 years later. Underlying the program were three congressionally mandated goals: to construct a coherent, unified income assistance system; to eliminate large disparities between the States in eligibility standards and benefit levels; and to reduce the stigma of welfare through administration of the program by SSA. It was the hope, if not the assumption, of the Congress that a central, national system of administration would be more efficient and eliminate the demeaning rules and procedures that had been part of many State-operated public assistance programs. SSI consolidated three State administered public-assistance programs: old age assistance; aid to the blind; and aid to the permanently and totally disabled.

Under the SSI program, States play both a required and an optional role. They must maintain the income levels of former public-assistance recipients who were transferred to the SSI program. In addition, States may use State funds to supplement SSI payments for both former public-assistance recipients and subsequent SSI recipients. They have the option of either administering their supplemental payments or transferring the responsibility to SSA.

SSI eligibility rests on definitions of age, blindness, and disability; on residency and citizenship; on levels of income and assets; and, on living arrangements. The basic eligibility requirements of age, blindness, or disability have not changed since 1974. Aged individuals are defined as those 65 or older. Blindness refers to those with 20/200 vision or less with the use of a corrective lens in the person's better eye or those with tunnel vision of 20 degrees or less. Disabled persons are those unable to engage in any substantial gainful activity because of a medically determined physical or mental impairment that is expected to result in death or that can be expected to last, or has lasted, for a continuous period of 12 months.

As a condition of participation, an SSI recipient must reside in the United States or the Northern Mariana Islands and be a U.S.

citizen, an alien lawfully admitted for permanent residence, or an alien residing in the United States under color of law. In addition, eligibility is determined by a means test under which two basic conditions must be satisfied. First, after taking into account certain exclusions, monthly income must fall below the benefit standard—$407 for an individual and $610 for a couple in 1991. Second, the value of assets must not exceed a variety of limits.

Under the program, income is defined as earnings, cash, checks, and items received "in kind," such as food and shelter. Not all income is counted in the SSI calculation. For example, the first $20 of monthly income from virtually any source and the first $65 of monthly earned income plus one-half of remaining earnings, are excluded and labeled as "cash income disregards." Also excluded are the value of social services provided by federally assisted or State or local government programs such as nutrition services, food stamps, or housing, weatherization assistance; payments for medical care and services by a third party; and in-kind assistance provided by a nonprofit organization on the basis of need.

In determining eligibility based on assets, the calculation includes real estate, personal belongings, savings and checking accounts, cash, and stocks. In 1990 and years thereafter, the asset limit is $2,000 for an individual and $3,000 for a married couple. The income of an ineligible spouse who lives with an SSI applicant or recipient is included in determining eligibility and amount of benefits. Assets that are not counted include the individual's home; household goods, and personal effects with a limit of $2,000 in equity value; $4,500 of the current market value of a car (if it is used for medical treatment or employment it is completely excluded); burial plots for individuals and immediate family members; a maximum of $1,500 in burial funds for an individual and the same amount for a spouse; and the cash value of life insurance policies with face values of $1,500 or less.

The Federal SSI benefit standard also factors in a recipient's living arrangements. If an SSI applicant or recipient is living in another person's household and receiving support and maintenance from that person, the value of such in-kind assistance is presumed to equal one-third of the regular SSI benefit standard. This means that the individual receives two-thirds of the benefit. In 1990, that totaled $257 for a single person and $386 for a couple. In 1991, the SSI benefit standard for individuals living in another person's household will increase to $271 for a single person and $407 for a couple. If the individual owns or rents the living quarters or contributes a pro rata share to the household's expenses, this lower benefit standard does not apply. In 1990, 5.8 percent, or 273,000 recipients came under this "one-third reduction" standard. Sixty-seven percent of those recipients were receiving benefits on the basis of disability.

When an SSI recipient enters a hospital, or nursing home, or other medical institution in which a major portion of the bill is paid by Medicaid, the SSI benefit amount is reduced to $30. This amount is intended to take care of the individual's personal needs, such as haircuts and toiletries, while the costs of maintenance and medical care are provided through Medicaid.

B. ISSUES

1. BENEFITS

Ever since the program's start-up in 1974, benefit levels have fallen below the poverty level. As a result, the program has relieved, but not eliminated, poverty rates among elderly and disabled individuals. The poverty rate among the elderly has declined only marginally from 14.6 percent in 1974 to 11.4 percent in 1989. For the black elderly, the poverty rate is even greater, at 31 percent. The poverty rate is highest for black elderly women, at 37 percent. The 1990 benefit of $407 per month left an elderly individual 22 percent below the 1990 poverty level of $6,268 per year. For elderly couples, the maximum benefit level of $610 was 7 percent below the projected poverty level of $7,906 in 1990. In 1989, out of a total population of 29.6 million elderly 65 and over, 3.4 million had incomes below the poverty level.

A 1988 study by the National Council of Senior Citizens found that the average low-income elderly household had an annual income of $5,306. Of that amount, housing costs totaled more than 38 percent, food 34 percent, and home energy 17 percent. This left about $493, or $9.38 a week, for discretionary spending.

Under SSI, States may also voluntarily supplement the Federal SSI benefit. Approximately 42 percent of SSI recipients receive such supplementation. However, the median State supplement in 1990 was only $37 for an individual per month and eight States provide no supplement. Only four States—Alaska, California, Massachusetts, and Connecticut supplement SSI enough to bring benefits up to the poverty level.

In an effort to extend the effectiveness of SSI, anti-poverty advocates, joined by a number of national aging and disability organizations, have pushed for increasing the Federal benefit standard to the poverty level.

2. INCOME AND ASSETS LIMITS

An additional concern stems from the fact that the SSI program's cash income disregards have not been updated to reflect inflation. The Urban Institute has calculated that if the 1983 values of such disregards had been indexed they would have increased from the current $20 of monthly income from any source and $65 of monthly earned income to $40 and $30 respectively. The $20 disregard affects almost 90 percent of elderly beneficiaries.

Compounding this shortcoming is the absence of regular indexing for the asset limits individuals must meet to receive SSI benefits. Through the program's first 10 years, the allowable asset limits remained constant at $1,500 for individuals and $2,250 for couples. In 1984, however, the Deficit Reduction Act (P.L. 98–369) raised these limits annually through 1989 by $100 for individuals and by $150 a year for couples to its current level of $2,000 and $3,000 respectively. Even so, anti-poverty advocates remain concerned that the asset test is still too stringent and disqualifies otherwise eligible persons.

The results of a 1988 study conducted by the Policy Center on Aging of Brandeis University for the American Association of Retired Persons (AARP), support this contention. The study found that 34 percent of the income eligible 65–69 age group and 45 percent of the 85 and over age group were ineligible because of assets. The study also reported that a significant number of individuals possessed assets close to the cutoff. For example, about 60,000 elderly persons had countable assets that fell within $750 of the 1984 asset test threshold. The assets held by a majority of the asset ineligible population were interest earning accounts, homes, and automobiles. About half of income eligible/asset ineligible elderly households had modest life insurance policies that contributed to ineligibility.

Among the reforms of SSI that have been advocated to address this problem are the elimination of the asset test, the use of the less stringent Food Stamp asset test in its place, and indexation of the asset test. Using 1984 costs, the Brandeis study estimated the impact of such changes. Elimination of the asset test would be the most expensive, the study found, because it would increase the eligible population by 42 percent and increase the cost of Federal benefits by 34 percent, or between $800 million and $1.2 billion annually. Use of the food stamp test, which in 1988 permitted $3,000 in assets, would increase the eligible population by 15 percent and Federal benefits by 12 percent, for a total cost of between $300 and $400 million. Indexing for inflation would increase the eligible population by 7 percent and increase Federal costs by 5 percent, or between $100 and $200 million.

Overall, the Brandeis study raised the issue of whether the current SSI asset test furthers the Federal goal of alleviating poverty among the truly needy. The study concluded that many of the elderly are excluded from SSI not because they are well-off, but only because the government has failed to take into account the impact of inflation on program eligibility criteria.

A broad coalition of anti-poverty advocates, in conjunction with a number of Members of Congress, have included reform of the SSI program's income and asset tests among their priority objectives.

3. Low Participation

Since its inception, the SSI program has been plagued with low participation rates. Despite initial projections that over 7 million Americans were eligible for SSI, the caseload has never exceeded 4.7 million. Further, the number of elderly participants has continued to decline. The number of those persons who became eligible for SSI on the basis of age declined from 2.3 million in 1975 to 1.4 million in 1990. A 1986 study by the Commonwealth Fund Commission on Elderly People Living Alone found evidence that those who are eligible but not participating are mostly single elderly women living in poverty.

Over the years, studies have found that only between 40 and 60 percent of the elderly poor enough to qualify for SSI actually receive benefits under the program. A 1980 study, based on 1975 population data, of the Institute for Research on Poverty found a 41 to 47 percent participation rate for the elderly. In the following year, 1981, Urban Systems reported a participation rate of 60 percent, using a nonrepresentative 1979 survey of low-income elderly.

More recently, a 1988 AARP study prepared under a grant from the Commonwealth Fund Commission on Elderly People Living Alone, found that only 51.1 percent of those eligible were participating in SSI, with rates varying between 30 to 60 percent among the States.

A related 1988 AARP survey, conducted by Lou Harris and Associaties, found that over half of the eligible poor who were not participating in SSI had never heard of the program or did not know how to apply for assistance. Less frequently cited reasons for nonparticipation included an inability to deal with the program's application process, language barriers, the stigma of receiving welfare, the loss of privacy, and the perception of low benefits.

Significantly, the AARP survey also identified a number of effective SSI outreach tools. The largest number of elderly respondents, 76 percent, reported that one-on-one assistance with the SSI application process would be an effective approach. About 72 percent reported that allowing individuals to set up an appointment time with SSA, rather than spending time waiting in a SSA field office, would further program participation. Slightly fewer, 68 percent, said that informing individuals that SSI eligibility confers access to health care through Medicaid would make a difference, followed closely by increasing benefits (67 percent) and allowing individuals to apply for SSI at some location other than an SSA field office (66 percent).

The findings of an April 1989 report of Families U.S.A., formerly the Villers Foundation, confirms that the major obstacle toward greater SSI participation among the elderly is a lack of information and understanding about the program. Based on a survey of over 6,000 low-income elderly, the study found only one-third of the respondents knew that SSI could raise an eligible person's income and one-fourth were aware that SSI eligibility could lead to health care under Medicaid. The study also reported that the perceived complexity of the SSI application process and the lack of assistance in completing the application forms serves to keep many eligible individuals the application forms serves to keep many eligible individuals off the rolls. Finally, the report concluded that SSI outreach efforts on the part of SSA were limited, sporadic, and untargeted, and that a nationwide effort was critical to ensure that eligible individuals are able to receive the benefits under the program.

On a demonstration basis, AARP and the Commonwealth Fund Commission on Elderly Living Alone worked in 1988 with dozens of local agencies in three cities to develop and test ways to increase participation in the SSI program. The projects pioneered a number of innovative strategies, making extensive use of the media, community education, and one-on-one counseling of potential SSI applicants. In the three cities—El Paso, Pittsburgh, and Oklahoma City—SSA reported an average increase of about 97 percent in applications and about 58 percent in awards. In 1989, these projects served as templates for SSI outreach programs in 10 additional locations.

In recent years, SSA itself has undertaken some outreach activities, but they have been limited in scope and undertaken only after strong congressional pressure. In 1984, for example, a congressionally mandated effort by SSA to inform 7.6 million potential SSI recipients by mail to possible eligibility resulted in 79,000 applications—representing 1 percent of potential recipients who were alerted. A total of 58,000 of those who applied where awarded benefits.

The chronic low rates of program participation has led to criticism of the agency for failing to take a more aggressive approach to this problem and to provide better training to SSA staff in this area. Many also voice strong concern over the impact of the agency's closing of field offices, staff reductions in field offices, particularly field representatives and those with bilingual capability, and the lack of outreach efforts in minority communities.

Over the last several years, SSA resources most critical to the agency's outreach efforts—field representatives and contact stations—have been scaled back significantly. Between 1986 and 1989, the number of field representatives dropped by 28 percent and the number of contact stations by 22 percent.

Adding to the barriers to increased SSI participation was the nationwide implementation of an SSA toll-free line. Under the new system, all calls to SSA bypassed SSA field offices and were rerouted to a small number of SSA telephone centers. Although 1990 legislation required SSA to provide telephone access to local offices, in its first years of operation the toll-free line was persistently plagued with a high incidence of busy signals and incomplete or erroneous answers, particularly with respect to the SSI program. One SSA study, for example, revealed that nearly one in four callers (24 percent) with questions about SSI were given incorrect answers. (For a fuller discussion of SSA's toll-free line, please see chapter 1.)

4. Representative Payees

Under SSA's representative payee program, an individual other than the beneficiary is appointed to handle checks from the Social Security and SSI programs when the beneficiaries are deemed unable to manage their own finances. The monthly payments to approximately 1 million SSI beneficiaries are handled by representative payees. By definition, beneficiaries in need of a payee are vulnerable.

Intense concern over the lack of safeguards to protect beneficiaries from abuse by representative payees was triggered in 1988 when police in Sacramento, CA, uncovered the bodies of eight Social Security beneficiaries in the backyard of Mrs. Dorothea Puente, an operator of an unlicensed board and care home. Mrs. Puente, who previously had been convicted for Social Security fraud, was appointed as a representative payee for one of the beneficiaries, whose murder she later was charged with committing.

At a March 1989 hearing of the House Social Security Subcommittee and a hearing a month later of the Senate Special Committee on Aging, a number of witnesses, including legal services attorneys and SSA claims representatives, characterized problems of abuse within SSA's representative payee program as pervasive. Witnesses point to SSA's lack of adequate screening and monitoring of payees as the major factor causing these problems.

A 1983 study by SSA of payees under Social Security found problems with payees in as many as 20 percent of cases. Also, the study revealed that more than 4 percent of the cases called for a change in the payee, while 1.5 percent of those reviewed did not even need a payee. Limtied in scope, this study excluded SSI recipients and relatives serving as payees.

Until 1978, SSA conducted limited monitoring of payees receiving Social Security. In that year, however, SSA discontinued this practice as a cost-saving measure. In the following year, SSA was challenged in a class action suit, known as the *Jordan* case, for abandoning its monitoring program and leaving beneficiaries vulnerable to abuse. In 1981, while the case was still pending, SSA also halted its monitoring program for payees under the SSI program.

Citing due process protections, in 1983 the court ruled in *Jordan* that SSA must conduct "mandatory periodic accounting" of *all* payees. Following that protracted but unsuccessful appeal by SSA, the agency ultimately was faced with a more stringent order to establish a monitoring program of "universal annual accounting." During this same period, legislation was enacted into law that would have exempted relatives from the monitoring requirements, but which the *Jordan* court subsequently voided.

To carry out the *Jordan* ruling, SSA in 1988 finally began requiring all payees to fill out a form listing estimated amounts of the expenditures in various categories. If the beneficiary or a third party contests the validity of the information provided by the payee, or the totals did not add up, only then was SSA required to look into the situation, typically by telephoning the payee and asking for an explanation. As a routine matter, SSA did not verify or audit the information provided by payees.

Although the policy of SSA was to investigate the fitness of individuals applying to serve as a payees, little in the way of a background check were being conducted. Only in the wake of the Puente case did SSA begin to verify the applicant's identification and to *ask* if the applicant has ever been convicted of a felony. Under current law, individuals convicted of Social Security fraud violations are prohibited from serving as payees.

Recently, in *Holt* v. *Bowen* a Federal district court ordered the agency to repay Mr. Holt, an SSI beneficiary whose lump sum benefits were stolen by a payee with a criminal record. The judge noted SSA was liable because the agency failed to conduct even a minimal investigation into the payee's background. Although the *Holt* case was not a class action suit, Mr. Holt's story illustrates the financial abuse to which beneficiaries are vulnerable, according to legal service attorneys and protective service workers.

These lapses by SSA prompted Congress to intensify oversight of the program and legislation was enacted to strengthen SSA's procedures, which is discussed below. In anticipation of that legislation, and in response to congressional concern, SSA moved on its own in 1990 to address some of the weaknesses that had been identified in its representative payee program.

5. SSI MODERNIZATION PROJECT

SSA Commissioner Gwendolyn King in 1990 established the Supplemental Security Income Modernization Project. This excellent initiative is undertaking a comprehensive examination of the SSI program, reviewing its fundamental structure and purpose. The purpose of the Project is to determine if the SSI program is meeting and will continue to meet the needs of the population it is intended to serve in an efficient and caring manner. The Project is operating under the recognized constraints of the current fiscal climate.

As SSA has explained it, the first phase of the Project is intended to create a dialog that provides a full examination of how well the SSI program serves the needy, aged, blind, and disabled. To begin the dialogue, Commissioner King has involved 25 people who are experts in the SSI program and related public policy fields. The experts include a wide range of representatives of the aged, blind, and disabled from private and nonprofit organizations and Federal and State government as well as former SSA staff. Dr. Arthur S. Flemming, former Secretary of Health, Education, and Welfare, chairs the Project. Dr. Flemming, and many of the experts serving the Project, are widely recognized as being among the foremost advocates for improving and protecting the SSI program. These choices attest to Commissioner King's commitment to making the Project effective and successful in meeting its admirable goals.

The Project is holding a series of meetings across the Nation in 1990 and 1991. The meetings are designed to facilitate the sharing of ideas among attendees' constituencies, including advocacy groups, State and local government officials, and academicians. The meetings will inform the public and bring to the Project's attention individually produced innovative ideas for change in the SSI program.

The Project is expected to produce a report with recommendations to Commissioner King sometime in the late summer of 1991. Judging from the Project's efforts and composition thus far, those recommendations will be thoughtful and well constructed, and will set the agenda for the SSI program in years to come.

6. EMPLOYMENT AND REHABILITATION FOR SSI RECIPIENTS

Section 1619 and related provisions of SSI law provide that SSI recipients who are able to work in spite of their impairments can continue to be eligible for reduced SSI benefits and Medicaid. The number of SSI disabled and blind with earnings has increased from 87,000 in 1980 to 198,000 in 1990. In addition, 26,000 of aged SSI recipients had earnings in 1990.

Before 1980, a disabled SSI recipient who found employment faced a substantial risk of losing both SSI and Medicaid benefits. The result was a disincentive for disabled individuals to attempt to work.

The Social Security Disability Amendments of 1980 (P.L. 96-265) established a temporary demonstration program aimed at removing work disincentives for a 3-year period beginning in January 1981. This program, which became section 1619 of the Social Security Act, was meant to encourage SSI recipients to seek and engage in employment. Disabled individuals who lost their eligibility status for SSI because they worked were provided with special SSI cash benefits and assured Medicaid eligibility.

The Social Security Disability Benefits Reform Act of 1984 (P.L. 98–460), which extended the section 1619 program through June 30, 1987, represented a major push by Congress to make work incentives more effective. The original section 1619 program preserved SSI and Medicaid eligibility for disabled persons who worked even though two provisions that set limits on earnings were still in effect. These provisions required that after a trial work period, work at the "substantial gainful activity level" (then counted as over $300 a month earnings, which has since been raised to $500) led to the loss of disability status and eventually benefits even if the individual's total income and resources were within the SSI criteria for benefits.

When an individual completed 9 months of trial work and was determined to be performing work constituting substantial gainful activity, he or she lost eligibility for regular SSI benefits 3 months after the 9-month period. At this point, the person went into section 1619 status. After the close of the trial work period, there was, however, an additional one-time 15-month period during which an individual who had not been receiving a regular SSI payment because of work activities above the substantial gainful activities level could be reinstated to regular SSI benefit status without having his or her medical condition reevaluated.

The Employment Opportunities for Disabled Americans Act of 1986 (P.L. 99–643) eliminated the trial work period and the 15-month extension period provisions. Because a determination of substantial gainful activity was no longer a factor in retaining SSI eligibility status, the trial work period was recognized as serving no purpose. The law replaced these provisions with a new one that allowed use of a "suspended eligibility status" that resulted in protection of disability status of disabled persons who attempt to work.

The 1986 law also made section 1619 permanent. The result has been a program that is much more useful to disabled SSI recipients. The congressional intent was to ensure ongoing assistance to the severely disabled who are able to do some work but who often have fluctuating levels of income and whose ability to work changes for health reasons or the availability of special support services.

This is of particular importance to elderly parents of adult mentally retarded or mentally ill children. At issue is the continued availability of income assistance, medical care, housing, and social services for their children. Such services are often provided by the parents themselves, both financially as well as the day-to-day care and supervision of their adult disabled children. Many of these aging parents would like to set up trust accounts to provide for the children's care following their parents' death. However, the income from, and resources of, such a trust may cause a child to be ineligible for SSI and therefore unable to utilize the work incentive provisions of section 1619.

Under present law, an individual must have 1 month of regular SSI benefits before they qualify for the work incentive provisions of section 1619. The result is that an individual who is only receiving SSDI, when losing their disability status due to work activity, cannot move into the SSI section 1619 program. The House of Representatives approved a provision in 1989 which allows an SSDI recipient who becomes ineligible for SSDI as a result of earnings to participate in section 1619 without first being required to receive at least 1 month of SSI benefits. This proposal, which was not enacted in 1990, will remain on the agenda for 1991.

Four important improvements in the section 1619 work incentive program were enacted in 1990 as part of the Omnibus Budget Reconciliation Act (P.L. 101-508). The first eliminates the age limit on eligibility for the program, so that a person who is in the section 1619 program will be permitted to continue in it after becoming 65 years old. The second provision requires that impairment related work expenses be excluded from the earnings of a disabled individual in determining State supplementary payments and Federal SSI benefits. Previous law permitted only disabled persons who receive Federal SSI benefits to deduct impairment-related work expenses from income in determining SSI eligibility and re-eligibility. The The third provision authorizes reimbursement for vocational rehabilitation services provided in months for which individuals were eligible for Medicaid coverage under section 1619(b), were in suspended benefit status, or were receiving federally administered State supplementary payments. Under previous law, State vocational rehabilitation agencies already were reimbursed for the costs incurred by regular SSI recipients and section 1619(b) recipients. The fourth provision prevents SSA from conducting more than one continuing disability review annually, even if the person returns to work and participates in the section 1619 program. Under previous law, a disabled or blind individual with income fluctuations was subject to several disability reviews in the course of a year.

Congress and advocates for individuals with disabilities remain highly interested in work incentives, and are impressed with the progress of the section 1619 program. More refinements, and possibly more broad-based expansions of the program, can be expected in the future.

7. IMPROPER SUSPENSION OF BENEFITS

A SSA study, obtained by the Senate Special Committee on Aging in late 1989, revealed that the benefits of thousands of SSI recipients had been unfairly and improperly denied in 1987 and 1988. In view of the fact that individuals who qualify for SSI are extremely low-income, either as a result of advanced age or a disabling condition, these improper suspensions of benefits likely caused extreme hardship.

In 1987, SSA suspended payments to over 80,000 SSI recipients on the grounds that they failed to respond to the agency's request for information concerning eligibility and payment status. In 1988, the number increased to over 105,000 individuals. An SSA analysis of a selected number of these cases showed that many of these improper suspensions were a result of an agency failure to allow the individuals in question sufficient time to respond. Even in cases complicated by a mental disability, advanced age, or a language barrier, the agency generally made no special effort to contact the recipients before cutting off their benefits. SSA policy requires that a follow-up contact be made in these cases.

A major factor for the lack of compliance with SSA policy requiring follow-up stems from a heavy workload, according to the study. Also cited was a desire to avoid overpayment of benefits to recipients. In light of these findings, the study concluded that SSA must take special care in determining when to suspend benefits.

In response to the study's findings, Commissioner Gwendolyn King strongly criticized the staff of the agency over the handling of the SSI cases. In a speech to SSA staff the Commissioner stated, "I will not tolerate this happening again. If one, just one, beneficiary is wrongly denied his or her benefits, that is a tragedy, nothing less. We will not permit such tragedy to take place." In 1990, she took steps to establish procedures which will prevent the problem from occurring in the future. Five Senators, including Aging Committee Chairman David Pryor, Senator John Heinz, the Committee's Ranking Minority Member, and Senators Moynihan, Riegle, and Chafee, cosigned a letter to President Bush praising her decisive response to this problem.

C. CONGRESSIONAL RESPONSE

In response to the mounting concern over inadequacies of the SSI program, comprehensive reform legislation, along with a number of bills targeting specific program problems, were introduced in the 101st Congress. Despite the ambitious scope and cost of these bills, a combined effort of a broad coalition of aging and disability organizations and key Members of Congress promoted this legislation. At the conclusion of the 101st Congress, however, only relatively low-cost provisions were actually enacted.

1. Comprehensive Reform Legislation

Early in 1989, a coalition of Members in the House of Representatives—including, Representative Edward Roybal, Chairman of the Select Committee on Aging, and Representatives Robert Matsui and Downey—mounted a legislative campaign to increase the SSI benefit to the poverty level, raise the assets level from $2,000 to $4,200 for an individual (from $3,000 to $6,300 for a couple), mandate SSI outreach and make a number of technical improvements to the program. Some important provisions were included in the proposed reconciliation bill passed by the House of Representatives in 1989. Due to an impasse between the House and the Senate over unrelated provisions in their respective versions of this bill, the SSI reforms were ultimately dropped.

On the Senate side, Senator John Heinz, the Ranking Minority Member of Special Committee on Aging, also sponsored a bill, S. 665, to raise the SSI resource limit, require the establishment of an SSI outreach program, and reform a number of other SSI policies pertaining to disabled children.

Despite making some legislative progress, these bills were not enacted in the 101st Congress. The focus of Congress in 1990 was upon the bipartisan budget summit with members of the Bush administration which aimed at reducing the budget deficit. In this climate, costly bills to increase SSI benefit or to relax SSI resource tests were not seriously considered. Under the 5-year deficit reduction agreement made by the budget summit, these proposals are not likely to progress easily in the near future. Nevertheless, advocates plan a grass-roots campaign to promote such changes, and sympathetic Members of Congress will join their efforts.

2. SSI Outreach

Senator David Pryor, Chairman of the Special Committee on Aging was among the principal sponsors of SSI outreach legislation. Provisions in his bill, S. 600, would require that SSA establish an SSI outreach program and work closely with the activities of nonprofit organizations toward this end. Although the Senate Finance Committee voted to include these provisions in its proposed reconciliation package, they were ultimately dropped from the final version of this legislation and were not enacted in the 101st Congress.

Working on a separate legislative track to achieve the same goal of increased participation in the SSI program, $3.5 million in funding was included in the fiscal year 1990 Health and Human Services Appropriation Act (P.L. 101-166) to establish an SSI outreach program within SSA. Under the Act, SSA is encouraged to work with the Administration on Aging (AoA) and the Area Agencies on Aging in these efforts. (Although the Older Americans Act was amended in 1987 to create a new authorization for outreach services through AoA to older persons who may be eligible for SSI, Medicaid, and food stamps, no funds were appropriated.)

Amid widespread congressional concern over poor rates of SSI participation, the new SSA Commissioner Gwendolyn King has made SSI outreach among her top objectives.

3. Representative Payee Reforms

In 1990, a major package of legislation was enacted reforming SSA's representative payee programs. The provisions were based on legislation introduced by Representative Jacobs, the Chairman of the Social Security Subcommittee, Representative Levin, and Senate Aging Committee Chairman David Pryor. The bill mandates stringent screening and monitoring of individuals applying for or acting as a payee. The legislation grew out of hearings held in 1989 by the Social Security Subcommittee of the House Ways and Means Committee and the Senate Special Committee on Aging.

Provisions from Senator Pryor's bill were initially included in the Senate's 1989 reconciliation package, but later dropped from that legislation for procedural reasons. The House also approved provisions in 1989 that were ultimately stripped from the final OBRA package. In 1990, the Finance and Ways and Means Committees had opportunity to carefully consult each other and work out an agreement resolving the differences between their respective 1989 legislative proposals. The result was a comprehensive package of reforms that encompassed the best elements from both the House and Senate approaches.

The final package enacted by Congress includes a number of improvements in the investigation and monitoring of representative payees, and a number of protections designed to safeguard beneficiary rights.

The investigation component requires SSA to verify representative payee applicants' identities, conduct face-to-face interviews with them to the extent practicable, verify their Social Security numbers, determine whether they have been convicted of a Social Security felony such as fraud, and determine whether they were ever dismissed as a representative payee in the past for misuse of beneficiary funds. SSA would be precluded from appointing anyone as a representative payee who has been convicted of a Social Security felony or who has misused beneficiary funds in the past. Exceptions can be made if SSA determines in writing that due to extraordinary circumstances it would otherwise be in the beneficiary's best interest.

A series of new recordkeeping requirements are established by the legislation to strengthen SSA's ability to investigate and to oversee representative payees. First, SSA must establish and maintain a list of those who are terminated for misuse of beneficiaries' funds, and to provide that list to local field offices. Second, SSA is required to maintain a centralized list which is readily retrievable by all SSA offices of the address and Social Security number of each representative payee, and of each person the representative payee is providing services.

To protect beneficiaries, limits are established on who can serve as a payee. A creditor or individual providing goods and services to a beneficiary cannot serve as his or her representative payee, except in certain specified cases. These exceptions include a person who is a relative and who lives in the same household as the beneficiary, a person who is a legal guardian or representative, a facility licensed or certified under State or local law, an administrator, owner, or employee of such a facility in cases when the beneficiary resides there and SSA has made a good faith effort to find an alternative payee, or in cases when SSA makes a written determination that the person poses no risk to the beneficiary, that no substantial conflict of interest exists, and that no other representative payee can be found.

The legislation also establishes new rules regarding payment and withholding of benefits by SSA. Where SSA cannot fund anyone to serve as representative payee, direct payment will be made to the beneficiary unless SSA determines that it would cause the beneficiary "substantial harm". Where SSA makes this finding, benefits can only be withheld for up to 30 days. At the end of that period, SSA would begin direct payment except where the person has been declared legally incompetent or is under age 15. Exceptions to direct payment are only to be made in extraordinary cases.

To protect beneficiary rights, appeals and notice procedures are established. The beneficiary will have the right to appeal SSA's determination of the need for a representative payee and the specific person selected to serve in that capacity. Notice of an SSA determination on the need for a payee must be in writing. Notices must be provided in advance of any benefits being paid to a representative payee. They must be clearly written, easily understandable, and explain the person's rights.

To provide further protection, where SSA negligently fails to investigate or monitor a representative payee, and the result is misused benefits, SSA will be required to repay the beneficiary. SSA is required to make a strong effort to recover the funds from the representative payee who misused them.

SSA is required under the new law to study and provide recommendations as to the feasibility and desirability of formulating stricter accounting requirements for all high-risk categories of representative payees. High risk categories are defined as nonrelated payees who do not live with the beneficiary, those who serve as payee for five or more persons and who are not related to them, creditors of the beneficiary, and any other group determined by SSA to be high risk. Congress will revisit this issue after receiving SSA's study.

Finally, the legislation allows organizations that were providing representative payee services to numbers of individuals for a fee before October 1988—to restore those services. This provision, based on a bill by Senator Riegle of Michigan, was designed considering the needs of Guardian, Inc., of Calhoun County, MI, which had been providing badly needed services that were shut down by SSA. Under the new law, the fee can be taken from the person's benefit but may not exceed the lesser of 10 percent of the monthly benefit amount or $25.

In 1991, Congress will carefully oversee SSA's implementation of the new law to ensure it is done in accord with congressional intent. Significant administrative resources will be required of SSA to accomplish the goals of the legislation. Concerns have been raised that SSA's difficult budgetary situation in 1991 will complicate that effort. Congress will have to take the burden placed on SSA by this legislation into account when appropriating funds for SSA's administrative budget.

4. SSI Technical Improvements

The 1990 Omnibus Budget Reconciliation Act (P.L. 101-508) included a number of improvements in the SSI program. Among these, the Act liberalized the treatment of certain income by disregarding expenses and payments in determining SSI eligibility and/or benefits. Pursuant to the 1990 law, SSA is to (1) exclude victim's compensation payments from income for purposes of SSI eligibility and benefits, and exclude such payments from resources for the 9-month period beginning after the month of receipt, (2) treat royalties and honoraria as earned income rather than unearned income, and (3) exclude State or local relocation assistance from income and from resources for no more than 9 months. In addition, the legislation extends the presumptive eligibility time period from 3 months to 6 months. Under previous law, a person who is determined to be presumptively disabled was entitled to receive SSI benefits for 3 months while the person's application was being adjudicated. Often, the 3 months of benefits had ended before SSA had made a determination on the application.

D. PROGNOSIS

Over the last several years, in recognition of SSI's role as the major element in the Nation's safety net for poor elderly and disabled individuals, the Congress has exempted the program from budget cuts. Nevertheless, Federal spending constraints have precluded any program expansion and, as a result, the SSI eligibility criteria have lost ground to the effects of inflation. At the same time, program benefits continue to lag behind the amount needed to pull recipients out of poverty.

In 1990, budgetary pressures frustrated congressional efforts to correct these program deficiencies. No doubt in coming years the obstacles to achieving significant SSI expansion will remain difficult to overcome. An encouraging development in this area, however, is the decision of the coalition of aging and disability organizations, which mobilized support for these reforms in 1989, to redouble its efforts in 1991 and beyond. Nevertheless, to the extent that additional Federal resources are directed toward expanding SSI, they likely will be achieved on a basis that is incremental rather than sweeping.

The successes of 1990—most particularly, the enactment of legislation to reform SSA's representative payee program—provide evidence of Congress' continued commitment to improving these programs within budgetary constraints. In addition, the recommendations of the SSI Modernization Project will certainly accelerate the debate and contribute critical support for important reforms.

Continued congressional emphasis on SSI outreach efforts also can be expected. Despite SSA's positive initiatives, concern remains strong that word is not getting out to those most in need of Federal assistance. Similarly, congressional oversight of SSA is likely to ensure that administrative problems do not adversely affect SSI benefits and that SSI recipients and others can get accurate and timely answers to questions over the agency's new toll-free line.

Chapter 6

FOOD STAMPS

OVERVIEW

During the 1980's, Congress enacted laws that both restricted and liberalized the Food Stamp Program. In 1981 and 1982, eligibility was greatly limited and benefit increases were delayed or eliminated. Later, following passage of the 1985 Farm Bill and the 1988 Hunger Prevention Act, many of the major restrictions enacted in the early 1980's were removed and new provisions liberalizing the program were added. Today's Food Stamp Program looks much like that in place at the beginning of the decade.

In 1990, the major legislative initiative affecting food stamps was the Mickey Leland Memorial Domestic Hunger Relief Act, which was title XVII of the 1990 omnibus "farm bill". The Food, Agriculture, Conservation, and Trade Act of 1990 (P.L. 101-624) extended the authorization for food stamp appropriations through fiscal year 1995 and made relatively minor changes in the Food Stamp Act, adding no new net Federal costs.

Early in 1990, it was expected that substantial changes to the Food Stamp Program, including benefit increases and provisions easing eligibility and access to the program, would be enacted. Indeed, significant liberalizations and spending increases for food stamps were incorporated in the House version of the farm bill. However, they were largely eliminated from the final measure when it became clear that, under the terms of the 1990 budget "summit" agreement on deficit reduction, no new money would be available for domestic food assistance, beyond that already called for by inflation adjustments and changes in program enrollment.

In 1991, advocates are likely to seek reconsideration of provisions dropped from the 1990 legislation, and to draw attention to the expected growth in the food stamp caseload. Proposals which address the needs of children at nutritional risk will be the most likely to receive serious congressional attention.

A. BACKGROUND

The Food Stamp Program works to alleviate malnutrition and hunger among low-income persons by increasing their food purchasing power. State welfare agencies, following Federal regulations established by the U.S. Department of Agriculture (USDA), issue food coupons that eligible households may use in combination with the other income to purchase a more nutritious diet than would otherwise be possible.

In 1990, an estimated 21.5 million low-income persons participated in the program, with an average monthly benefit of about $59 per person. This includes about 1.5 million persons a month in Puerto Rico under the Nutrition Assistance Program (NAP), a block grant which has replaced the Food Stamp Program there. The Food Stamp Program is available to households which meet certain asset and income tests or which already receive benefits under the Aid to Families with Dependent Children (AFDC) or the Supplemental Security Income (SSI) programs. It is estimated that a minimum of 30 million people in the United States may actually be eligible to receive food stamps. Over the past decade, average monthly participation has ranged from a low of 17.7 million persons in fiscal year 1979 to a high of 23.2 million in fiscal year 1983.

The origins of the Food Stamp Program can be traced to an eight-county, experimental anti-hunger project established by Executive Order in 1961. A national expansion of the project concept followed passage of the Food Stamp Act of 1964. After 1964, all States were given the option to offer a coupon distribution program in lieu of their existing commodity donation projects. In 1977, Congress enacted the Food Stamp Act of 1977, fundamentally revising the program's benefit structure, eligibility criteria, and administrative scheme. Since then, Congress has enacted amendments intended to improve the Food Stamp Program and strengthen its integrity.

Eligible applicants receive monthly food stamp allotments to buy food through standard market channels, usually authorized grocery stores. These stores then forward the commercial banks for cash or credit. The stamps flow through the banking system to the Federal Reserve Bank where they are redeemed out of a special account maintained by the U.S. Treasury Department. The Food Stamp Program serves as an income security program by supplementing family income. It also contributes to farm and retail food sales and helps reduce surplus stocks by encouraging increased food purchases.

Recent studies confirm the correlation between nutritional status and health, especially for the young and the old, underscoring the true significance of the Food Stamp Program. The program has some special rules for the elderly—including more liberal treatment of shelter costs, medical expenses, and assets. The program, for example, recognizes that elderly people with high medical bills may have total incomes higher than poverty level, but less money actually available for food than others with lower incomes and no medical bills. For the 12 percent of elders who take the medical deduction for the elderly, the average deduction is nearly $70 per month, providing an increase in benefits of nearly $20 per month.

Although 20 percent of food stamp households have at least one elderly member (age 60 or older), they make up only 8 percent of food stamp recipients and receive 8 percent of food stamp benefits because elderly households are typically smaller (an average of 1.5 persons) and have relatively higher incomes than recipient households of the same size. Ninety percent of all elderly participants live alone or with one other person, usually elderly as well. Seventy percent live alone, of which 80 percent are single elderly females. More than 10 percent of elderly households also include children. Eighty-seven percent of elderly recipients have liquid assets of $500 or less, with an average of $184 per household.

The Federal Government pays 100 percent of all food stamp benefits and 50 percent of most State and local administrative costs. State and local costs for expanding computer capability and fraud control activities are eligible for 75 percent Federal funding. The Food and Nutrition Service of the Department of Agriculture is responsible for administering and supervising the Food Stamp Program and for developing program policies and regulations. At State and local levels, the Food Stamp Program is administered by State welfare departments.

The elderly may qualify for special assistance in applying for food stamps though Social Security offices if they are applicants for, or recipients of, Social Security or SSI benefits. Many advocacy groups, however, contend that Social Security offices are not providing needed assistance in many cases. In order to evaluate how effectively these offices are assisting potential food stamp beneficiaries, Congress last year passed a measure, sponsored by Senator David Pryor, which directed the Comptroller General to comprehensively examine this issue.

State and local Welfare offices are also required to establish and implement special procedures for those who have difficulty applying for food stamps at the welfare offices and for those with extremely low incomes who need food stamps quickly, e.g., out-of-office application procedures, permission to use "authorized representatives" to apply for and use food stamps, and "authorized representatives" to apply for and use food stamps, and "expedited service" for those in extreme need. Benefits must be provided to eligible households within 30 days of application, or within 5 days for those in extreme need.

Uniform national household eligibility standards for program participation are established by the Secretary of Agriculture. All households must meet a liquid assets test and, except for those with an elderly or disabled member, a two-tiered income test to be eligible for benefits. Recipients of two primary Federal-State categorical cash welfare program—AFDC and SSI—are automatically eligible for food stamps, although in California and Wisconsin increased SSI benefits replace food stamp assistance. An eligible household's monthly gross income must not exceed 130 percent of the income poverty levels set annually by the Office of Management and Budget (OMB), and its monthly income (after deducting amounts for such things as medical and dependent care, shelter, utilities, and work-related expenses) must be equal to or less than 100 percent of the OMB poverty level.

To be eligible, a household cannot have liquid assets exceeding $2,000, or $3,000 if the household has an elderly member. The value of a residence, personal property and household belongings, business assets, burial plots, a portion of the value of a vehicle, and certain other resources are excluded from the liquid assets limit.

Certain able-bodied household members (older than 16–18 years of age, depending upon their school and family status, and younger than 60 years) who are not working must register for employment and accept a suitable job, if offered one, to maintain eligibility. States are required to operate Employment and Training (E + T) programs under which adults who are registered for work and not subject to certain exemptions must fulfill State work program requirements. These may include workfare obligations, supervised job search requirements, participation in a training program, or other employment or training activities designed by the State.

Applicant households certified as eligible are entitled to a monthly benefit amount calculated from their income and size. A food stamp household is expected to contribute 30 percent of its monthly cash income after expense deductions (or about 15–20 percent of its gross income) to food purchases. Food Stamp benefits then make up the difference between that expected contribution and the amount needed to buy a low-cost adequate diet; this amount is the maximum monthly benefit and is equal to the cost of the USDA's "Thrifty Food Plan," adjusted for household size and inflation and increased by a special 3 percent "add on." In fiscal year 1991, the maximum food stamp benefit is $105 a month for a one-person household and $193 for a two-person household. Average monthly benefits in 1990 were $59 per person and about $40 among elderly recipients. However, about one-quarter of elderly households receive only the minimum $10 a month benefit.

B. ISSUES

As mentioned, significant changes in the Food Stamp Program were considered in 1990, but largely dropped, when Congress was faced with a budget summit agreement that did not include the funding to pay for them. In 1991, Congress may revisit proposals for food stamp liberalization which failed to receive action in the 101st Congress if new money can be found in the budget. The emerging recession and rapidly rising food stamp enrollment will play a role in the considerations as these are expected to drive food stamp benefits and ease access to the program. In light of the possibility of future amendments to the Food Stamp Program, it may be useful to review some of the studies released during the 1970's and 1980's which appear to demonstrate the need for an expanded program.

1. Prevalence of Hunger in America

Hunger in America captured Congressional attention soon after a visit to the rural South in April 1967, by members of the Senate Subcommittee on Employment, Manpower and Poverty. The subcommittee held hearings on the effectiveness of the so-called war on poverty and was told of widespread hunger and poverty. Later that year, a team of physicians found severe nutritional problems in various areas of the country. These and other reports of hunger and malnutrition in America led to an expansion of Federal food assistance programs. In 1977, physicians returned to evaluate progress made in combating hunger in these same communities and found dramatic improvements in the nutritional status of their residents. These gains were attributed to the expansion of Federal food programs in the 1970's.

Throughout the 1980's, considerable attention was focused on the re-emergence of widespread hunger in the United States. Since 1981, at least 32 national and 43 States and local studies on hunger have been published by a variety of government agencies, universities, and religious and policy organizations. They all suggest that hunger in America is widespread and entrenched, despite national economic growth.

In 1981, news accounts of bread lines and crowded soup kitchens began to appear in papers in various cities around the country. In 1982, the U.S. Conference of Mayors reported that in most cities surveyed, the need for food represented a true emergency. In 1983, the Conference issued a report which detailed a significant increase in requests for emergency food assistance citing unemployment as a primary cause.

Closely following that report, the General Accounting Office found significant increases in the number of persons seeking food assistance during the early 1980's, including substantial numbers of persons who had recently been financially stable. In 1983, Senator Edward Kennedy issued to the Senate Committee on Labor and Human Resources a report based on a field investigation undertaken the week before Thanksgiving, 1983. Senator Kennedy found that hunger was on the rise in America and that Congress must act to improve assistance to the hungry.

The Center on Budget and Policy Priorities surveyed private nonprofit agencies which operate emergency food programs across the Nation and reported in 1983 that more than half of the 181 programs surveyed increased the number of free meals or food baskets they provided by 50 percent or more from 1982 to 1983. Nearly one-third of the programs also doubled in size over that time.

Later that year, President Reagan appointed a commission to investigate allegations of rampant hunger in the United States. At the end of 1984, the President's Task Force of Food Assistance concluded that there was little evidence of widespread hunger in the United States and that reductions in Federal spending for food assistance had not injured the poor. Several modest recommendations to make the Food Stamp Program more accessible to the hungry were outlined in the report, including:

(1) Raising asset limits,

(2) Increasing the food stamp benefit to 100 percent of the Thrifty Food Plan,

(3) Categorical eligibility for AFDC and SSI households,

(4) Targeted benefit increases to beneficiaries with high medical or shelter expenses (particularly the elderly and disabled), and

(5) Modification of the permanent residence requirement so benefits are available to the homeless.

These liberalizations, however, were offset by cost-reduction measures which included increasing the State responsibility for erroneous payments and an optional State block grant for food assistance.

The Food Research and Action Center (FRAC) also surveyed nationally the use of emergency food programs during the early 1980's. In 1983, FRAC found that food stamp recipients were the majority users of emergency food programs, mostly because they ran out of stamps by the second or third week of the month. It was reported that those who did not receive food stamps either did not know they were eligible, had applied and been turned down, or did not know how or where to apply. FRAC also reported that between 1983 and 1984, there was an average monthly increase of 20.4 percent of the number of households served nationally by emergency food providers and a 17 percent per month increase between 1984 and 1985. As a result of budget cuts and changes in the law, FRAC concluded that the Food Stamp Program was neither assisting the eligible poor in an adequate fashion nor reaching the population most at risk of hunger.

The Harvard School of Public Health, after 15 months of research into the problem of hunger in New England, concluded in 1984 that:

(1) Substantial hunger exists in every State in the region,

(2) Hunger is far more widespread than generally has been realized, and

(3) Hunger in the region had been growing at a steady pace for at least 3 years and was not diminishing.

The researchers found that greater numbers of elderly persons were using emergency food programs and that many were suffering quietly in the privacy of their homes. The staff also expressed concern over what had been noted in clinical practices: Increasing numbers of malnourished children and greater hunger among their patients, including the elderly. The staff also cited the impact of malnutrition on health and stated that children and elderly people are likely to suffer the greatest harm when food is inadequate.

The Physicians Task Force on Hunger in America, established in 1984, has issued periodic reports on the nature and scope of the hunger problem, including regional and group variations. Through the Harvard School of Public Health, it also has assessed the health effects of hunger and made recommendations to remedy the problem. The group's 1984 report concluded: (1) That hunger was reaching epidemic proportions across the Nation, (2) that hunger was worsening, and (3) that increasing hunger could be attributed to the Federal policies. The report estimated that up to 20 million Americans may be hungry at least some period of time each month.

In 1986, the Task Force identified 150 "hunger counties" in the United States with high poverty levels and low food stamp participation. A high concentration of "hunger counties" was identified in the Midwest and North Central States. The report concluded that the level of participation in the Food Stamp Program appeared to be most closely related to a county's efforts to enroll the poor in the program rather than the county's poverty rate.

Later that year, the Task Force issued another report examining barriers to participation in the Food Stamp Program to determine why food stamp coverage was declining when hunger was increasing. It concluded that, while poverty had increased between 1980 and 1985, food stamp participation by those eligible had decreased because of conscious Federal policy changes that resulted in barriers to food stamp participation, keeping State and local food stamp programs from reaching more needy people. Many recommendations were made to provide outreach, increase access, and liberalize the program.

In 1987, the Physician Task Force on Hunger issued a report which noted that, despite 5 years of economic growth, hunger in America had not been reduced significantly. More people were living in poverty, many of them the working poor and the long-term unemployed, the report found. The Task Force cited a strong downward pressure on wages, with the share of after-tax household income dropping for every income category since 1980 except the highest 20 percent. Furthermore, new persons were entering the hunger ranks, including former oil workers in the South, farm families in the Midwest, service workers of California, and miners and steelworkers in the East and Midwest. The report also noted the several factors that may contribute to increased hunger: (1) 25 percent of the population lives at the poverty level at some time during the year, (2) the income gap between rich and poor families had reached its widest point in four decades, and (3) Government programs designed to assist the poor had less impact in the mid-1980's than in 1979.

A study released in 1986 by Public Voice for Food and Health Policy found that the rural poor were less likely to consume adequate nutrients than were the nonpoor and that rural poor children experienced stunted growth at an alarming rate. Low birth weights and high infant mortality rates were found to be significantly higher in poor rural counties than in the rest of the Nation. Also, while many poor elderly persons live in rural areas, only 31 percent of these households receive food stamp benefits. The study also concluded that the rural poor were significantly less likely to participate in any public assistance programs.

(A) HUNGER AND MALNUTRITION AMONG THE ELDERLY

According to medical experts on aging, malnutrition may account for substantially more illness among elderly Americans than has been assumed. The concern about malnutrition is rising fast as the numbers of elderly grow and as surveys reveal how poorly millions of them eat. The New York Times reported in 1985 that scientists estimate that from 15 to 50 percent of Americans over the age of 65 consume fewer calories, proteins, essential vitamins, and minerals than required for good health. According to the article, gerontologists are becoming alarmed by evidence that malnourishment may cause much of the physiological decline in resistance to disease seen in elderly patients—a weakening in immunological defenses that commonly has been blamed on the aging process. Experts say that many elderly fall into a spiral of undereating, illness, physical inactivity, and depression. Recent findings suggest that much illness among the elderly could be prevented through more aggressive nutritional aid. In the view of some physicians, immunological studies hold promise that many individuals may lighten the disease burden of old age by eating better. Being poor also greatly exacerbates the effect of nutrition problems. Low participation in the Food Stamp Program leaves large numbers of Americans without enough to eat and the problems exist largely because many people who are eligible for food stamps are not receiving them.

A 1987 National Survey of Nutritional Risk Among the Elderly by the Food Research and Action Center found that 18 percent of the low-income elderly who responded said they did not have enough money to buy the food they needed, 35 percent usually ate less than three meals a day, and 5.4 percent were without food for more than 3 days in the last month. Yet about a third of this sample seldom or never participated in congregate meals programs and only about 25 percent participated in the Food Stamp Program.

A 1985 report by the GAO, based on research conducted by private organizations, USDA, and the President's Task Force on Food Assistance concluded that nonparticipation in the Food Stamp Program by many low-income households was attributed to factors including:

(1) Lack of awareness regarding household eligibility for the program;

(2) Relatively low benefit payments may provide little incentive for eligible elderly to apply;

(3) Administrative requirements such as complex application forms and required documentation;

(4) Physical access problems such as transportation or the physical condition of the applicant; and

(5) Attitudinal factors, including sensitivity to the social stigma associated with receiving food assistance.

One 1982 study estimated that only 50 percent of the eligible elderly in the United States participate in the Food Stamp Program. Participation was especially low among elderly people who live alone, and the older people were, the less likely they were to participate. This may have been due to a lack of awareness of the household's eligibility for the program. Thirty-three percent of eligible nonparticipants believed they were not eligible for food stamps and another 36 percent were not sure.

(B) FOOD STAMP PARTICIPATION STUDIES

A November 1988 study by the Congressional Budget Office again indicates the low rate of participation in the Food Stamp Program by those eligible. According to then current census data, only 41 percent of eligible households and 51 percent of eligible individuals received food stamps in 1984. Eligibility conditions were, however, more strict at that time. Participation levels were the highest for very-low income households and individuals. Participation rates ranged from 67 to 90 percent for those who were eligible to receive over $100 in benefits per month. Eligible families with children also had higher participation rates, as many also participated in AFDC. Households with elderly members had lower participation rates of 34 to 44 percent. The lowest participation rates were for households without children or elderly members.

Studies released by GAO, in July and October 1988, examined and analyzed data regarding nonparticipation in the Food Stamp Program. Lack of information about the program and problems with administrative barriers were cited as the most common reasons for not taking advantage of the program. GAO examined eight studies, all of which found that the likelihood of household participation rates in the Food Stamp Program decreases as the age of the head of household increases, or as the number of the people aged 65 or older in the household increases. The GAO cited several administrative procedures which discouraged participation including: limited office hours and restricted interviewing schedules, requirements that households complete screening forms before filling out food stamp applications or being interviewed, failure of some offices to consider applicants for expedited benefits, and the lack of assistance in obtaining needed documents for applications.

In 1989, USDA's Food and Nutrition Service released two studies examining Food Stamp Program participation rates. USDA found that participation rates were not as low as some earlier studies had suggested. Nevertheless, it concluded that some vulnerable populations, including the elderly, experience very low participation rates. USDA findings included the following: (1) 66 percent of eligible individuals and 60 percent of eligible households participated in the Food Stamp Program in 1984; (2) participating households received 80 percent of all benefits that would have been paid, if all eligible households had participated; (3) 74–82 percent of eligible persons who had income at or below the poverty line were participating in the Food Stamp Program; and (4) only 33 percent of eligible elderly individuals participated in the Food Stamp Program.

(C) RECENT STUDIES

In 1990, preliminary results of the Community Childhood Hunger Identification Project (CCHIP), a major ongoing scientific study of the hunger among families with children, became available. Four CCHIP sites reported disturbing statistics regarding the prevalence of hunger among low-income families (ranging from 29 percent in Pontiac, MI, to 42 percent in Seattle, WA) and the number of poor families at risk of hunger (ranging from 67 percent in Pontiac to 80 percent in Hennepin County, MN).

Also in 1990, the U.S. Conference of Mayors released a 30-city survey of hunger and homelessness in urban areas. Local officials reported a 22 percent average increase in requests for food assistance. The vast majority of surveyed cities were forced to turn away needy persons due to inadequate resources. When asked to identify the principal causes of hunger, city officials most frequently cited employment-related problems which reduced household income and food purchasing power.

(D) PROPOSED RESPONSES TO HUNGER IN AMERICA

Drawing on the findings of these studies of the 1970's and 1980's, a number of recommendations for improvement and expansion of the Food Stamp Program were put forward in Congress, many of which were enacted into law in 1985 and 1988. In addition to amendments that reversed cut-backs made in the early 1980's, other improvements included a 3 percent add-on to food stamp benefit levels, additional benefits for those with high shelter and child care expenses, new employment and training programs for food stamp recipients, and restructuring the program's "quality control" system (where States are subject to fiscal sanctions when they have very high rates of erroneous benefit and eligibility determinations).

Major proposals to increase participation and improve benefits in the Food Stamp Program were considered by Congress in 1990, but not enacted. These proposals included: increasing the current 3 percent add-on to 5 percent (an across-the-board increase in all recipients' benefits); targeted benefit increases for those with higher shelter or dependent care expenses and those receiving child support payments; provision for continued, unreduced benefits when eligibility lapses briefly during reapplication; greater protection for recipients suffering hardships, such as large rent increases; a reduction in the degree to which vehicles are counted as liquid assets; less restrictive rules for relatives sharing housing; and an increase in the asset limit for the disabled. Added Federal support for E + T programs, automated data processing computerization, and outreach activities also fell by the wayside. Taken together, these proposals would have increased food stamp spending by some $4.5 billion over the next 5 years.

C. CONGRESSIONAL RESPONSE

1. Fiscal Year 1990 Appropriations

Under the Agriculture appropriations bill for fiscal year 1990 (H.R. 2883), $15.7 billion was appropriated for the Food Stamp Program, including $937 million in nutrition assistance for Puerto Rico. The House Committee on Appropriations' version of the fiscal year 1990 appropriations for the Agricultural Department included $14.2 billion for food stamps. The Senate Appropriations Committee, in its version of the fiscal year 1990 Agricultural appropriations measure, included $15.4 billion for the Food Stamp Program. The Congressional Budget Office had projected program costs for 1990 to be $15.7 billion. Spending for food stamp benefits and the Federal share of State administrative costs is protected from sequestration under the Gramm-Rudman-Hollings deficit-reduction bill.

2. 1990 Legislation

Although Congress enacted far fewer changes to the Food Stamp Program than had been anticipated by many advocates, several important improvements were nevertheless signed into law. Among the significant new provisions are the following:

(1) Less restrictive eligibility and benefit rules for postsecondary students applying for food stamps;

(2) Providing special benefits for homeless households in "transitional" housing;

(3) Reducing the degree to which some State and local general assistance support is counted as income when paid to third parties on recipients' behalf;

(4) Canceling fiscal year 1983–85 "quality control" fiscal sanctions pending against States for high rates of erroneous benefit and eligibility determinations;

(5) Easing rules for some disabled persons in Guam and the Virgin Islands;

(6) Disregarding certain school clothing allowances;

(7) Disregarding certain assets that cannot be sold for a significant return;

(8) Liberalizing benefit rules for disaster victims;

(9) Indexing of the $10-a-month minimum benefit;

(10) Adding controls over sales taxes in future pilot projects involving cashing out food stamp benefits;

(11) Easing procedures for medical expense deductions, giving State agencies greater control over how and when recipients report changed circumstances;

(12) Reducing application signing requirements;

(13) Giving recipients a greater say in who is named "head of household";

(14) Expanding mail issuance of benefits in rural areas;

(15) Requiring aggregation of initial benefits for households in severe need;

(16) Removing the requirement for a single food stamp general assistance application where not practicable; and

(17) Permitting certain homeless households to use food stamps in restaurants serving them reduced-priced meals.

Of particular importance to the elderly were three provisions in the farm bill sponsored by Senator David Pryor and included in S. 2509, Federal Food Effort for the Elderly and Disabled (FEE). First, the farm bill indexes for inflation the minimum $10 food stamp benefit, rounding off the nearest $5. Most recipients of the minimum benefit are elderly and disabled households. The minimum benefit had not been changed since 1977 and had lost almost half of its food purchasing power in the intervening years. Second, the farm bill requires States to issue food coupons by mail to persons residing in rural areas. Lack of transportation to food stamp offices has been cited as a significant reason for low rural elderly participation in the Food Stamp Program. Third, USDA was encouraged to increase the use of processed commodities by elderly nutrition programs and required to establish demonstration projects permitting elderly projects to receive a wider variety of processed commodities.

D. REGULATORY AND JUDICIAL ACTION

There were no major regulatory or judicial decisions under the Food Stamp Program in 1990.

Of continuing interest, however, is the 1988 Supreme Court decision in the *United Auto Workers and United Mine Workers* v. *Lyng*. This case challenged the food stamp rule that renders an entire household ineligible for food stamps if the household contains a member who is on strike. USDA challenged a lower court decision which held in favor of the unions. The Supreme Court overturned the lower court decision, holding that the striker rule did not violate the equal protection clause or the freedom of family association.

E. PROGNOSIS

Although many persons interested in domestic nutrition programs were deeply disappointed that budgetary constraints prevented enactment of major improvements to the Food Stamp Program in 1990, it is important to recall that many valuable low-cost or no-cost changes were passed into law in 1990 (including several provisions of particular significance to the elderly, such as the indexing of the minimum benefit).

In 1991, advocates are certain to urge Congress to enact many items left out of last year's farm bill. However, it is difficult to see how resources can be found to fund substantial program expansions and new initiatives at this time, in light of the staggering Federal budget deficit and new budget process reforms which will make spending increases for entitlements, such as food stamps, far more difficult. Nevertheless, a distinct possibility is that modest nutrition proposals targeted to families with children, and perhaps coupled with children's health and education measures, may receive congressional attention in 1991.

Chapter 7

HEALTH CARE

OVERVIEW

One of the greatest challenges in the 101st Congress was the need to rein in health care costs to help reduce substantial Federal deficits while assuring older Americans access to affordable, high quality health care. As a result, the development of health care policy for the elderly was marked with a number of both victories and frustrations. Most notable among the victories are physician payment reform, major rural health care initiatives, and a successful effort to keep increases in beneficiary out-of-pocket costs to a minimum under the 5-year budget agreement. Physician payment reform was a response to the rapidly increasing Medicare Part B physician reimbursement costs; the rural health care initiative was enacted to address hospital closings that were beginning to threaten access to care in rural areas. And finally, although the initial 5-year deficit agreement included greatly increased out-of-pocket costs to Medicare beneficiaries, the final agreement in the Omnibus Budget Reconciliation Act of 1990 (P.L. 101-508) included relatively small increases in those costs.

The frustrations included the repeal of the Medicare Catastrophic Coverage Act (MCCA), the lack of enthusiasm surrounding the release of the Pepper Commission report, and the cuts taken to the Medicare providers under OBRA 1990. Medicare providers were cut a total of $34 billion over 5 years under the 1990 budget agreement—$13.7 billion from Part A payments to hospitals, $14.2 billion from Part B payments to physicians, outpatient care and durable medical equipment suppliers, and $6.3 billion under the Medicare as secondary payer program.

Despite these cuts, there were some Medicare program expansions, such as coverage for mammography screening and hospitalization services in a community mental health center. The difference in Medicare payment between urban and rural hospitals was also eliminated. Because OBRA 1990 was a 5-year agreement, theoretically, there will be no substantive changes made to the Medicare program for the next 5 years. Most Members of Congress consider the agreement made under OBRA 1990 with regard to the Medicare program to be ironclad—in other words, there will be no additional cuts made, and program expansions will occur only if an equal reduction is made elsewhere. Whether this will be the case remains to be seen. The President's fiscal year 1992 budget includes a request for additional cuts to providers. Although the Congress is likely to reject the President's request, their response to other issues and concerns that arise with regard to the Medicare program in light of the 5-year budget agreement is unknown.

A. MEDICARE

1. BACKGROUND

(A) HEALTH CARE COSTS AND EXPENDITURES

Prior to the mid-1970's, the cost of health care was not a major issue. Instead, expansion of access and the improvement of quality of care were foremost on the Nation's health policy agenda. As costs began to skyrocket, however, policymakers began to realize that controlling these increases had to become a priority, and much more attention was focused on the type of "bang" the Nation was getting for its bucks. Between 1965 and 1988, national health expenditures increased from nearly $41.6 billion (5.9 percent of gross national product) to $539.9 billion (11.1 percent of GNP).[1] (See chart 1.)

The role of the Federal Government in funding national health expenditures grew very rapidly in the 1960's. Between 1965 and 1967, Federal spending nearly doubled, rising from not quite 12 percent to nearly 24 percent of national health spending. From 1967 to 1980, Federal spending rose gradually, reaching 29 percent in 1980. Since then, the Federal share of national health expenditures has remained very steady. The Federal Government paid $157.8 billion or 29.2 percent of the Nation's health bill of national health expenditures in 1988.

Hospital care costs continue to be the largest component of the Nation's health care bill. In 1987, 39 percent ($211.8 billion) of national health care expenditures was paid to hospitals. During the same year, physicians were paid $105.1 billion or 19 percent of national health expenditures. (See Chart 2.)

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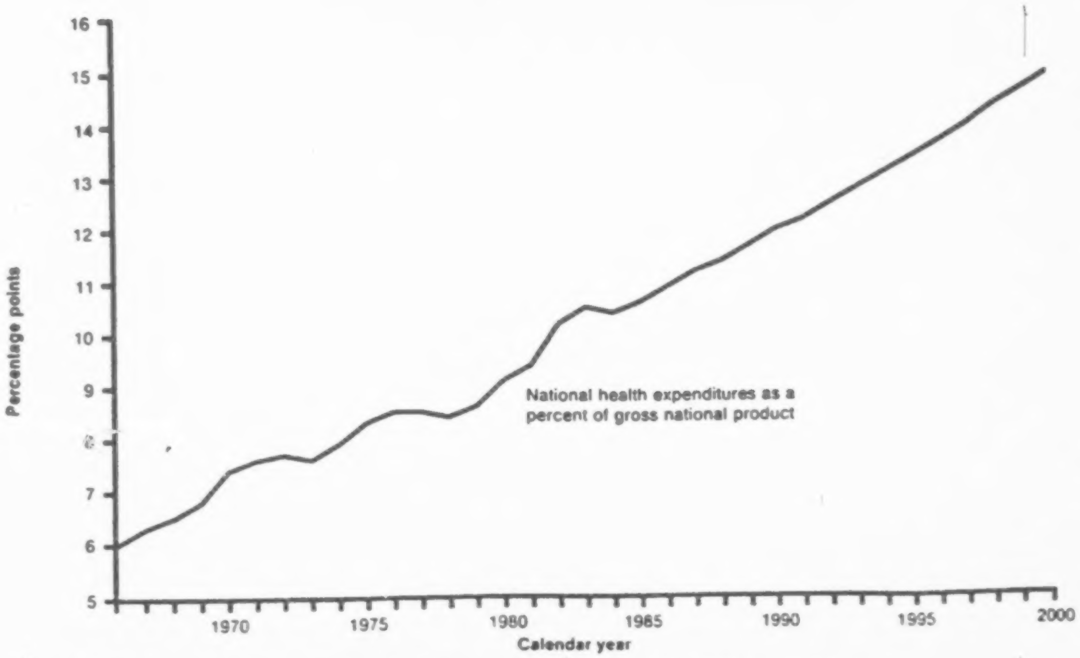
[1] HCFA Office of the Actuary: Data from the Office of National Estimates. Oct. 1988.

CHART 1

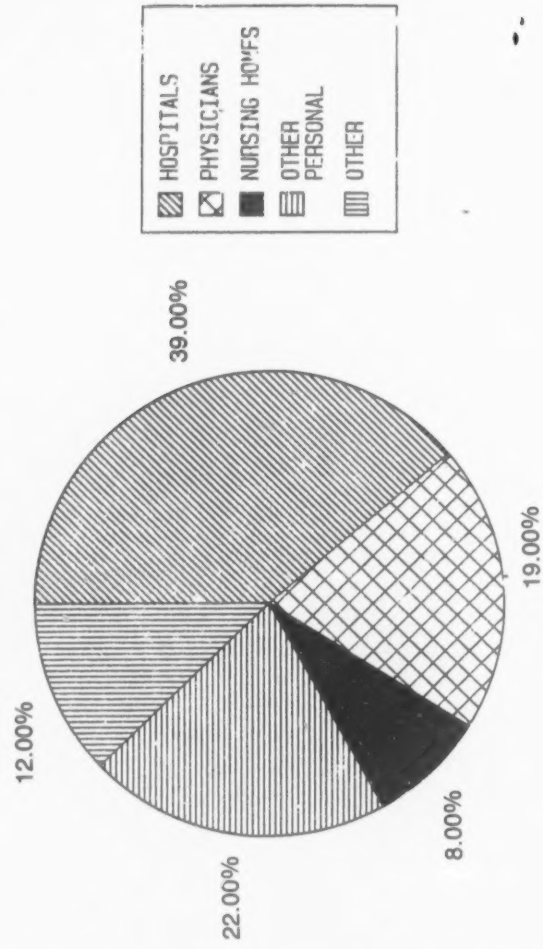
Percent change in national health expenditures as a percent of gross national product: Calendar years 1966-86 and projections 1987-2000



SOURCE: Health Care Financing Administration, Office of the Actuary: Data from the Division of National Cost Estimates.

CHART 2

WHERE OUR HEALTH DOLLAR WENT IN 1988



Source: National Health Expenditures, 1987, Health Care Financing Review, Winter, 1988

(1) Health Care Expenditures of the Elderly

Persons 65 and older, 12 percent of the population, account for more than one-third of the Nation's total personal health care expenditures. These expenditures represent total health care investment from all sources exclusive of research. In 1987 (the latest data currently available), total personal health care expenditures for the elderly were estimated at $162 billion and per capita spending reached $5,360. That represented a 13.6 percent average annual growth rate since 1977. It is particularly notable that older Americans spend as large a percentage of their income on health care needs (15 percent) as they did prior to the existence of Medicare.

(2) Hospitals

Hospital care for the aged cost $68 billion in 1987; this is an amount equal to $2,248 per capita. Medicare will reimburse about 70 percent of that total while other public funds will pay about 15 percent of the bill. Private health insurance will cover the remaining 15 percent.

(3) Physicians' Services

Spending for physicians' services to the elderly grew an average of 16 percent per year from 1977 to 1987, reaching a level of $33.5

billion in 1987.[2] Medicare spending accounted for an estimated 57.8 percent of the per capita expenditures (for the aged) for physician services in 1984 ($504 out of a total $868). During the period from 1980–83, Medicare physician expenditures increased (adjusted for inflation) at an average annual rate of 12 percent, compared to 6.5 percent of all physician expenditures. From 1983 to 1986, expenditures increased at an average annual rate of 9.1 percent and 7.2 percent, respectively.[3] The different rates of increase in expenditures suggest that Medicare beneficiaries receive a higher volume of physician services than the rest of the population.

(4) Home Health Services

As a percentage of total Medicare expenditures, the amount of reimbursement for home health care has been small. According to the Health Care Financing Administration, (HCFA) Medicare payments for home health care comprise a relatively small 2.7 percent of total program outlays. For fiscal year 1990, total reimbursements for Medicare home health services were projected to be $2.9 billion. Until recently, Medicare's home health benefit expenditures was one of the fastest growing components of the Medicare program.

(5) Cost Containment Measures

Throughout the last two decades, the structure and delivery of health care have been plagued by perverse incentives, resulting in the over-utilization of services, inefficiency, and waste. Led by the Federal Government, which faced major funding increases each year to pay for Medicare, Medicaid, and other health programs, third-party payers began to question whether large scale reform of health care was needed. In 1983, Congress and the administration created the prospective payment system (PPS) for Medicare reimbursement of hospitals, at the time the most dramatic change in Medicare reimbursment policy since its enactment.

Since the 1983 Medicare PPS reform, States have moved to adopt prospective payment methodologies for their Medicaid programs. Private payers, too, are supporting a hybrid of reimbursement reforms, ranging from prospective rate setting to innovative capitation schemes.

Facing continuing increases in payments to physicians, Congress in 1989 established a new payment system for physician services. Under this system, payments are to be made under a fee schedule based on a relative value scale (RVS) (a method of valuing individual services in relationship to each other). The RVS will be coupled with annual volume performance standards which are target rates of increase in physician expenditures. As with PPS, States and private payers are expected to adopt similar methods of reimbursement.

The health care arena is changing so rapidly on so many fronts that any broad characterization of it today is likely to be outdated tomorrow. Nevertheless, it seems fair to say that the overriding concern influencing the Nation's health care system is cost containment.

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[2] Waldo, Daniel R. et al. Health Expenditures by Age Group, 1977 and 1987. Health Care Financing Review. Vol. 10, No. 4, Summer 1989, page 114.

[3] Ibid., p. 112.

(B) HEALTH CARE UTILIZATION

Americans of all ages are healthier today than they were 10 to 20 years ago. While most older people report themselves to be in good to excellent health, many tend not to report specific health problems and mistakenly think they are caused by old age rather than disease. Yet age does affect a person's health, particularly the way the body reacts to disease and drugs.

Individual assessment of a person's own health is often the most important measure of health status and affects an individual's use of health services. Women over 65 tend to report better health than do men in the same age group.

Chronic diseases are a major threat to the independence of older persons. Arthritis, hypertension, heart conditions, and hearing disorders are leading chronic conditions among the noninstitutionalized elderly. Hospitalization of most older persons is caused by an acute episode of a chronic illness. Visits to the doctor also are most often for treatment of chronic conditions.

The dimensions of the current health services used by the elderly only hint at future needs. Health services usage by the elderly is growing because of absolute increases in the total aged population, greater number of individuals in the eldest subgroup, and an increased number of services provided per person. Greater expectation of good health, the availability of third-party financing, and increased access to medical advances such as renal dialysis and radiation therapy also are leading reasons for greater use of health services by the elderly.

(1) Hospital Utilization

Short hospital stays by the elderly increased by more than 57 percent between 1965 and 1986. In 1986, a survey of non-Federal short-stay hospitals revealed that 10.7 million elderly patients were discharged from hospitals, comprising 31.3 percent of all short-stay hospital patient stays. Those 75 and older accounted for 16.3 percent of short stays. According to the American Hospital Association's national hospital survey, the average length of stay for elderly patients had declined, from 10.8 days in 1977 to 8.9 days in 1988.

Older persons tend to stay in the hospital approximately 50 percent longer than and twice as often as the general population. The average hospital stay for persons 65-74 was about 8.2 days in 1987 compared with 9.1 days for the 85 and older group.

(2) Use of Physicians' Services

Utilization of physicians' services increases with age. Approximately 85 percent of the elderly living in the community had at least one contact with a physician in 1987. On average, the elderly are more likely than younger persons to make frequent visits to a physician. Persons 65 and older visit a physician nine times for every five times by the general population. Since the enactment of Medicare, the average number of physician contacts and the percentage of persons 65 and older reporting that they had seen a physician in the last year has increased significantly, particularly for persons with low incomes.[4]

Approximately 60 percent of physician visits by the elderly are made to a doctor's office. The remaining visits are divided among hospital emergency rooms, outpatient departments, and home and telephone consultations.

The aging of the population will increase the demand for physician care. Projections show that demand will increase by 22 percent from 1986 from 250 million physician contacts to 304 million contacts by the year 2000 and by 129 percent (more than 570 million visits) by 2030.[5]

Because chronic conditions are likely to increase with age, the health care needs of the elderly are broad in scope and require the participation of a number of health care professionals who specialize in geriatrics and gerontology. In addition, nurses have substantial responsibilities for providing services to the elderly in a wide range of settings such a hospitals, long-term care settings, ambulatory care programs and day care programs. Dentists, social workers, and allied health care professionals also can actively contribute to the care of the elderly when they understand the needs of older patients. Available data, however, indicate that only a small fraction of professional health care schools have programs in geriatrics and gerontology.

(3) Use of Home Health Services

Home health care has been one of the most rapidly growing Medicare benefits. There has been rapid growth in the number of participating agencies (from 3,000 in 1981 to more than 5,700 currently) as well as the volume of visits and services provided. Growth has begun to level off as a result of efforts by the HCFA to curtail growth. (See table 1.)

TABLE 1.—MEDICARE HOME HEALTH SERVICES

Year	Persons served (thousands)	Number of persons served per 1,000 enrollees	Total reimbursements (millions)	Total visits (millions)	Number of visits per 1,000 enrollees
1975	500	22	$215	11	431
1980	957	34	662	22	788
1983	1,351	45	1,398	37	1,227
1984	1,516	50	1,666	40	1,324
1985	1,589	51	1,773	40	1,279
1986	1,600	50	1,796	38	1,208
1987	1,565	48	1,792	36	1,113
1988	1,565	48	1,792	36	1,113

Source: HCFA.

The increase in home health utilization stems in part from legislative changes adopted in 1980 that removed certain payment, coverage, and participation restrictions from the home health benefit. Additionally, implementation of the PPS in 1983, with its incentives for more efficient management of health care resources, resulted in a significant drop in hospital lengths of stay and prompted a transfer of care from inpatient hospital settings to a variety of outpatient settings, including home health agencies. The decrease in home health utilization since 1985 may be a reflection of more stringent eligibility criteria and other administrative issues.

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[4] U.S. Senate Special Committee on Aging, America in Transition: An Aging Society. Washington, D.C., G.P.O., Sept. 1989, p. 96.

[5] Ibid.

The increasing lifespan, the aging of the elderly population, and the continuing advances in medical technology all suggest that more elderly Americans will suffer chronic conditions that limit their daily activities. Older Americans with chronic conditions will require extensive health care services, including home health care. It should be noted, however, that Medicare will only cover those home health services where a need for skilled nursing care or physical or speech therapy can be demonstrated. Most chronically impaired persons do not need skilled care to remain in their homes. Instead, they require nonmedical supportive care and assistance with basic self-care functions and daily routines that do not require skilled personnel. In 1986, Medicare beneficiaries over 85 were nearly four times more likely to receive home care services than Medicare beneficiaries aged 65–69. As the "old-old" population (those older than 85) increases, home care demand and utilization also will increase significantly.

(4) Use of Disease Prevention Services

Utilization of disease prevention services by the elderly varies by type of service. For example, elderly persons visit dentists less often than the younger population. In 1986, only 43 percent of those over 65 had visited the dentist in the previous year, while 57 percent of the general population did. Presently, older persons do not receive sufficient preventive or therapeutic dental care. It is estimated that almost one-third of the population is likely to lose some or all of their teeth between the ages of 50 and 70, primarily because of periodontal disease.

In contrast to the low incidence of dental care, 41 percent of the elderly in 1979–80 had one or more eye-care visits compared with 24 percent of those under 65. This percentage almost certainly would be higher if Medicare covered optical services and products.[6]

Many of the chronic conditions of the elderly are strongly associated with personal health habits. In general, there is only fragmented evidence that links changes in the health habits of older persons to reduced risk of disease. The most dramatic example of a behavior change that produces positive effects on health in cessation of cigarette smoking, which is a major risk in cardiovascular diseases and selected cancers. When a person of any age stops smoking, the benefits to the heart and the circulatory system begin right away. The risk of heart attack and stroke drops and circulation to the hands and feet improves. Nonsmokers also have a lower risk of contracting influenza and pneumonia, which sometimes can be life-threatening diseases for older persons.

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[6] Ibid., p. 123.

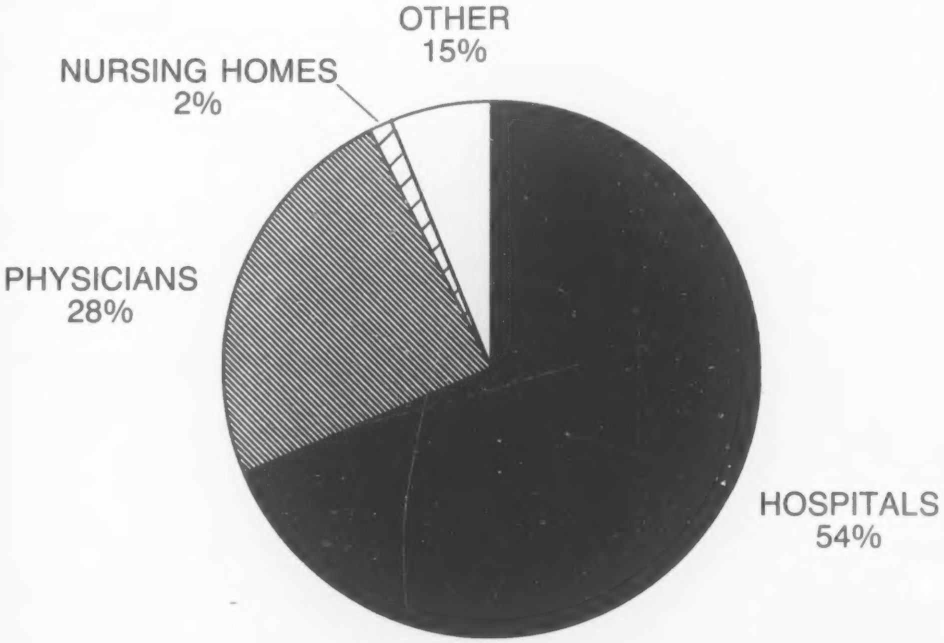
(C) MEDICARE PROGRAM DESCRIPTION

Medicare was enacted in 1965 to insure older Americans for the cost of acute health care. Over the past two decades, Medicare has provided millions of older Americans with access to quality hospital care and physician services at affordable costs. In 1990, Medicare insured 31 million aged and 3 million disabled individuals at a fiscal year 1990 estimated cost of $96.9 billion ($108.2 billion in gross outlays offset by $11.6 billion in beneficiary premium payments). Medicare is the second most costly Federal domestic program, exceeded only by the Social Security program.

As insurance for short-term acute illness, Medicare covers most of the costs of hospitalization and a substantial share of the costs for physician services (see Chart 3). However, Medicare does not cover all of the hospital costs of extended acute illnesses and does not protect beneficiaries against potentially large co-payments or charges above the Medicare payment rate for physician services. Approximately 70 percent of aged Medicare beneficiaries have private supplemental coverage, often referred to as Medigap insurance.

CHART 3

WHERE THE MEDICARE DOLLAR GOES: 1990 (est.)



SOURCE: Health Care Financing Administration,
Office of Financial and Actuarial Analysis, Unpublished data

Medicare (authorized under title XVIII of the Social Security Act) provides health insurance protection to most individuals 65 and older, to persons who have been entitled to Social Security or Railroad Retirement benefits because they are disabled, and to certain workers and their dependents who need kidney transplantation or dialysis. Medicare is a Federal program with a uniform eligibility and benefit structure throughout the United States. Protection is available to insured persons without regard to their income or assets. Medicare is composed of two parts—the Hospital Insurance (HI) Program (Part A), and the Supplementary Medical Insurance (SMI) Program (Part B).

(1) Hospital Insurance Program (Part A)

Part A is financed principally through a special hospital insurance payroll tax levied on employees, employers, and the self-employed. During 1989, each worker and employer paid a tax of 1.45 percent of the first $48,000 of covered employment earnings. The self-employed pays both the employer and employee shares. In 1990, each worker and employer paid 1.45 percent on the first $51,300 of covered earnings. In 1991, each worker and employee will pay a tax of 1.45 percent on the first $125,000 of covered earnings.

In calendar year 1989, payroll taxes for the HI Trust Fund amounted to $68.4 billion, accounting for 89.1 percent of all HI income. Interest payments, transfers from the Railroad Retirement Account and the general fund along with premiums paid by voluntary enrollees equaled the remaining 10.9 percent. Of the $60.8 billion in HI disbursements, $60 billion was for benefit payments while the remaining $800 million was spent for administrative expenses.

(a) Hospital reimbursement

The Medicare PPS pays hospitals fixed amounts that correspond to the average costs for a specific diagnosis. PPS uses a set of 477 diagnosis related groups (DRG's) to categorize patients for reimbursement. The amount a hospital receives from Medicare no longer depends on the amount or type of services delivered to the patient, so there no longer are incentives to overuse services. If a hospital can treat a patient for less than the DRG amount, it can keep the savings. If the treatment for the patient costs more, the hospital must absorb the loss. Hospitals are not allowed to charge beneficiaries any difference between hospital costs and the Medicare DRG payment.

(b) Catastrophic health care provisions

In 1988, the benefits and, to a smaller extent the financing, of the Medicare program were overhauled. On July 1, 1988, President Reagan signed the Medicare Catastrophic Coverage Act (MCCA) of 1988 into Public Law 100-360. A little over a year later, this law was repealed. The following are highlights of the major provisions of the MCCA as it relates to Part A of the program. Provisions retained or repealed by the Medicare Catastrophic Coverage Repeal Act of 1989 are noted. (A summary of the Part B benefits can be found in the next section and an extensive discussion of the development and repeal of the catastrophic health care legislation can be found in the Issues and Legislative Actions section of this chapter.)

Effective date.—The new Part A benefits became effective January 1, 1989, and were repealed on November 22, 1989.

Inpatient hospital services. (Repealed)—Specified a maximum of one hospital deductible per year ($560 in 1989) and eliminated the day limits, coinsurance charges, and spell of illness provisions.

Skilled nursing facility (SNF) services. (Repealed)—Required daily coinsurance payments for the first 8 days equal to 20 percent of the national average Medicare reasonable cost for SNF care (estimated at $20.50/day in 1989); eliminated coinsurance charges for 21st–100th days; added coverage for up to 150 days and eliminated prior hospitalization requirement.

Home health services. (Repealed)—Expanded the "intermittent" skilled nursing care definition so that "daily" care was defined as up to 7 days a week for 38 days (instead of 5 days a week for up to 2 or 3 weeks).

Hospice services. (Repealed)—Under this benefit, a beneficiary was able to elect to receive services for two 90-day periods and one subsequent 30-day period during his or her lifetime. The MCCA provided for a subsequent extension period beyond the current 210-day limit, if the beneficiary was recertified as terminally ill. This extension was subsequently enacted as part of OBRA 1990.

(2) Supplemental Medical Insurance (Part B)

Part B of Medicare, also called supplemental medical insurance, is a voluntary, non-means-tested program. Anyone eligible for Part A and anyone over age 65 can obtain Part B coverage by paying a monthly premium ($28.60 in 1990 and $29.90 in 1991). Part B covers physicians' services, outpatient hospital services, physical therapy, diagnostic and X-ray services, durable medical equipment, and certain other services. Part B is financed by a combination of beneficiary premiums, deductibles, and copayments, general revenues, and Part B trust fund interest. Under current law, premiums must cover 25 percent of program costs (i.e., actual program outlays); the remaining 75 percent are funded from general revenues.

In 1989, approximately 32 million people were covered under Part B. General revenue contributions totaled $30.9 billion, accounting for 69.6 percent of all income. Another 27.7 percent of all income was derived from premiums paid by participants, with interest payments accounting for the remaining 2.7 percent. Of the $38.8 billion in disbursements, $38.3 billion (96.3 percent) was for benefit payments while the remaining $1.5 billion (3.7 percent) was for administrative expenses.

(a) Physician reimbursement

Under a reimbursement system that will change in 1992, Medicare pays physicians the "reasonable" or "approved" charge rate for their services, less the deductible and the copayment. The reasonable charge levels for a service have been determined through a method referred to as customary, prevailing, and reasonable (CPR). Under CPR, payment for each service is limited to the lowest of: (1) the physician's actual bill for the service; (2) the physician's customary charge for the service; or (3) the prevailing charge for the service in that community. (Increases in the prevailing charge are limited by the Medicare economic index.)

To control ever-increasing Part B program expenditures and to provide beneficiaries with the opportunity to select a physician who has agreed to accept Medicare's "assigned" rate, the Deficit Reduction Act of 1984 (DEFRA, P.L. 98-369) established the concept of the participating physician. A participating physician voluntarily enters into an agreement with the Secretary of the Department of Health and Human Services (HHS) to accept assignment (Medicare's allowable reimbursement rate) for all services provided to all Medicare patients for a 12-month period. If assignment is accepted, beneficiaries are not liable for any out-of-pocket costs other than standard deductible and coinsurance payments.

A number of incentives have been implemented to encourage physicians to sign participation agreements. These include higher prevailing charge screens, more rapid claims payment, and widespread distribution of participating physician directories. In 1989, 40.2 percent of doctors were participating physicians.

To ensure that limitations on Medicare payments do not result in higher out-of-pocket costs for beneficiaries, the OBRA 1986 (P.L. 99-509), established maximum allowable actual charge limits (MAACs) which limit the actual charges of nonparticipating physicians during the 4-year period beginning on January 1, 1987. Under the MAAC limits, nonparticipating physicians with actual charges in excess of 115 percent of the prevailing charge are limited to a 1 percent annual increase in their actual charges. Nonparticipating physicians with lower actual charges may increase their charges at a more rapid rate so that in the fourth year their charges will equal 115 percent of the prevailing charge.

The OBRA 1989 made substantial changes in the way Medicare will pay physicians. The legislation provides for the establishment of a fee schedule based on a relative value scale (RVS). An RVS is a method of valuing individual services in relationship to each other. The RVS is coupled with annual volume performance standards which are target rates of increase in physician expenditures. Physician payment reform is discussed in depth later in this chapter.

(b) Catastrophic health care provisions

The MCCA made extensive revisions to the Part B benefit. The Catastrophic Coverage Repeal Act of 1989 repealed all of the revisions to the Part B benefit. The benefit changes, as well as the law's financing mechanism, are summarized below. Provisions retained or repealed by the Congress in 1989 are noted.

Effective date.—The Part B benefits were never implemented.

Limitation on out-of-pocket expenses. (Repealed)—Established a maximum out-of-pocket limit (the "catastrophic cap") on beneficiary liability for Part B cost-sharing charges after which Medicare will pay 100 percent of the approved amount. The limit was set at $1,370 in 1990; it was indexed so that a constant 7 percent of beneficiaries would be eligible for this catastrophic benefit each year.

Prescription drugs. (Repealed)—Established, effective January 1, 1990, a limited prescription drug benefit for home intravenous (IV) drugs and immunosuppressive drugs furnished after the first year following a transplant (they are already covered in the first year). The deductible was $550 in 1990; the coinsurance was 20 percent for home IV drugs and 50 percent for immunosuppressives. Provided coverage, beginning January 1, 1991, for all outpatient prescription drugs, subject to a $600 deductible and 50 percent coinsurance charges. The deductible was slated to go to $652 in 1992 and be indexed in future years so that 16.8 percent of beneficiaries would reach the deductible each year. The coinsurance was slated to be lowered to 40 percent in 1992 and 20 percent in 1993.

Medigap policies. (Amended to reflect repeal of catastrophic coverage)—Amended procedures for Federal certification of Medigap policies. Applied the National Association of Insurance Commissioners (NAIC) revision of Medigap minimum standards for purposes of Federal certification. Policies sold before enactment, but still in effect on January 1, 1989, were not to be deemed to duplicate Medicare's new benefits if they comply with the NAIC model transition rule which provides for refunds, or premium adjustments, when appropriate, for duplicable portions. Required a one-time notice to be sent to policyholders by January 1, 1989, on the new benefits, how they affect the policy's benefits and premiums and any adjustments that would be made.

Federal employees. (Repealed)—Required the Director of the Office of Personnel Management (OPM) to reduce, effective January 1, 1989, the rates charged to Medicare-eligible individuals participating in the Federal Employee Health Benefits Program (FEHBP) to reflect the amounts that would have been paid by those plans designed specifically for Medicare-eligible individuals. (See also supplemental premium tax deduction below.)

Maintenance of effort. (Repealed)—Under this benefit, any employer who provided health benefits to an employee or retired former employee (including State and local employees) that duplicated at least 50 percent of the new or improved Part A and Part B benefits would have to provide additional benefits or refunds that total at least the actuarial value of the duplicative benefits. The provision was effective with respect to Part A benefits in 1989 and was to be effective with respect to Part B benefits in 1990 except that an extension was provided to cover current collective bargaining agreements.

Medicaid. (Retained)—Mandated States, on a phased-in basis, to pay Medicare premiums, deductibles, and coinsurance for elderly and disabled individuals with incomes below the poverty line. Also, in the case of a couple where one member is institutionalized, the law directs the States to provide protection of up to $856 in 1990 of the couple's monthly income and up to $62,580 of their savings for the maintenance needs of the community spouse.

Respite care. (Repealed)—Provided coverage for in-home care for a chronically dependent individual for up to 80 hours per year. The benefit was only available for persons who meet either the catastrophic cap or the outpatient prescription drug cap.

Mammography screening. (Repealed)—Established a new Medicare benefit. Screenings for women over 65 would be covered every other year, subject to a maximum payment per screening of $50 in 1990 (indexed in future years). A modified version of this provision was included in OBRA 1990.

(c) Catastrophic coverage financing (Repealed)

The law was to be financed through a combination of (1) an increase in the monthly Part B premium for all Part B enrollees, and (2) a new supplemental premium which was to be mandatory for all those entitled to Part A who had Federal tax liability of $150 or more.

(3) Peer Review Organizations

Hospitals are required to enter into agreements with peer review organizations (PROs) as a condition for receiving payments under Medicare's PPS for inpatient hospital services. PRO's review the services provided to Medicare patients to assure that services are medically necessary, provided in the appropriate setting, and meet professionally recognized standards of quality health care.

The Secretary of HHS is required to contract with PROs. Organizations eligible for PRO contracts include physician-sponsored organizations, physician-access organizations, and health benefit payer organizations. PROs are expected to serve the dual role of curtailing unnecessary costs and assuring the quality of health care. However, in recent years, Aging Committee investigations have found that PRO's primary emphasis has been on controlling costs, rather than on assuring quality care.

There are 54 PRO contract areas. Each of the 50 States, the District of Columbia, Puerto Rico, and the Virgin Islands are designated as separate PRO areas. Guam, American Samoa, the Northern Mariana Islands, and the Trust Territory of the Pacific Islands are considered to be in a single PRO area. In these 54 PRO areas, HHS has contracted with 41 PROs to review the care provided in those areas.

The PRO review process begins after a Medicare beneficiary is discharged from the hospital and payment is made. Paid bill data is sent to the PRO, which selects a sample for review and requests the relevant medical records from the hospital. PRO reviewers (usually nurses) use criteria that contain the generally recognized reasons justifying a patient's hospital admission or surgical procedure. If the PRO reviewer determines that the care was not medically necessary or that it should have been provided in another setting (e.g., an outpatient facility), the PRO will issue a payment denial. A payment denial can only be made after the attending physician has been given an opportunity to discuss the case with a PRO physician. For the latest contract period, which began in June 1986 and continues through the present, 2.03 percent of all reviewed discharges were denied on the basis of inappropriate admissions. To help ensure Medicare reimbursement, some States require physicians to call the PRO for preadmission and extended stay approval.

(D) SUPPLEMENTAL HEALTH COVERAGE

At its inception, Medicare was not designed to cover its beneficiaries' total health care expenditures. Several types of services, such as long-term care for chronic illnesses, are not covered at all, while others are partially covered and require the beneficiary to pay deductibles, copayments, and coinsurance. Medicare covers approximately half of the total medical expenses for noninstitutionalized, aged Medicare beneficiaries. Other health care expenditures remain to be covered directly out-of-pocket, or with private supplemental health insurance, such as Medigap, by Medicaid, and other sources.

The term "Medigap" is commonly used to describe a private health insurance policy that is designed to supplement Medicare's coverage. There currently exists no survey that collects, on an ongoing basis, information about Medigap coverage. Several studies, however, have been conducted over the past couple years and are discussed below. In general, one can conclude from them that approximately 70 percent of those with Medicare (about 20 million persons) have some type of private supplemental health insurance coverage, although not all of it is Medigap. Approximately 40 percent of aged Medicare beneficiaries purchase private insurance; another 30 percent have employment-based coverage.

The Current Population Survey (CPS), conducted by the Census Bureau, collects information on other health insurance coverage held by Medicare beneficiaries. The survey does not collect information on Medigap insurance specifically, but rather on any type of health insurance that a Medicare beneficiary might hold, whether purchased privately or provided by an employer. According to preliminary data from the Congressional Research Service (CRS), the March, 1990 CPS found that approximately 70 percent of noninstitutionalized aged Medicare beneficiaries (19.1 million persons) had some type of private coverage in 1989. About 37 percent of these beneficiaries (10.4 million) had individually purchased, nonemployment-based private coverage. It is reasonable to assume that most of this coverage is through Medigap policies, although the survey does not provide this information.

A 1989 telephone survey of 1,500 aged individuals sponsored by the American Association of Retired Persons (AARP) found that approximately 60 percent of those surveyed had Medicare or Medicaid plus a Medigap policy. About 61 percent of this group had nonemployment-sponsored coverage (43 percent was individual coverage and 18 percent was group coverage) and 39 percent had an employment-sponsored group policy.

The Health Insurance Association of America (HIAA) conducted a national telephone survey of 500 older Americans (age 65 and older) in April and May 1989.[7] Of those surveyed, 78 percent had some type of private insurance to supplement Medicare. However, persons who were eligible for both Medicare and Medicaid were not included in this survey, as they typically do not purchase private health insurance. If these persons had been included, the rate of policy ownership would have been lower, about 70 percent.

The National Medical Expenditure Survey (NMES) was conducted in 1987 by the National Center for Health Services Research and Health Care Technology Assessment of HHS. Data from the first quarter of 1987 show that approximately 75 percent of the aged Medicare beneficiaries (about 20 million people) has some type of private health insurance.[8] Approximately 40 percent has privately purchased policies and 35 percent had employment-related coverage.

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[7] Rice, Thomas, Katherine Desmond, and Jon Gabel. *Older Americans and Their Health Coverage.* Health Insurance Association of America Research Bulletin, Oct. 1989. p. 15-20.

The HIAA survey found several factors relating to the likelihood of an older person having Medigap insurance. Those persons age 80 and under, whites, married, better educated, higher incomes, and those reporting better health status were all most likely to have one or more supplemental insurance policies. The differences were not great for most factors, with the exception of race: while 82 percent of whites had policies, only 33 percent of nonwhites did. Although income was not a factor above $10,000, data from CBO found that in 1984, only about 44 percent of the elderly with incomes below $5,000 had private supplemental insurance, compared to 87 percent of those with incomes of $25,000 and over.

The regulation of private insurance has traditionally been a State responsibility. However, the NAIC has developed model standards which can be adopted by States. These standards specify, among other things, the minimum benefits that a policy must cover. These were adopted by NAIC in the mid-1970's, and have been amended several times since then.

Despite the NAIC model law and regulations, abuses in the sale of Medigap policies persisted, leading Congress to include in the Social Security Disability Amendments (P.L. 96-265), enacted June 1980 a new Section 1882 entitled "Voluntary Certification of Medicare Supplemental Health Insurance Policies," also known as the Baucus amendment, after the chief sponsor of the amendment, Senator Max Baucus. Section 1882 established standards for Medigap policies based primarily on the June 1979, NAIC model standards. It establishes loss ratio requirements for group and individual Medigap policies. It also provides criminal penalties for certain abusive Medigap sales practices, including making false statements and misrepresentations, and selling policies that duplicate Medicare's benefits.

Until passage of OBRA 1990, the Federal Medigap standards were implemented in two ways. Individual insurers could voluntarily submit their policies to the Voluntary Certification Program to be certified. Or, recognizing the traditional role of States in regulating insurance, States could adopt the Federal Medigap standards as part of their regulatory program. If the State programs meet or exceed the Federal standards, then policies approved in those States are deemed to have met the Federal requirements, and the Voluntary Certification Program does not apply.

In December 1980, the NAIC revised its model standards to incorporate the requirements of the Baucus amendment. According to a 1986 GAO study of the Medigap market,[9] all but four States had adopted Medigap insurance regulatory programs as least as stringent as the NAIC standards. GAO reported that this resulted in more uniform regulation of Medigap insurance and increased protection for the elderly against substandard or overpriced policies.

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[8] Monheit, A., and C. Schur. *Health Insurance Coverage of Retired Persons.* National Medical Expenditure Survey Research Findings 2, National Center Health Services Research and Health Care Technology Assessment. HHS Publication No. (PHS) 89-3444, Sept. 1989, p. 8-10.

[9] U.S. Government, GAO, Report to the Subcommittees on Health, House Committee on Ways and Means, Medigap Insurance: Law Has Increased Protection Against Substandard and Overpriced Policies: October 1986.

Most large commercial insurers, with premiums of $50 million or more, met the loss ratio requirements of Section 1882. However, more than 60 percent of the commercial insurance policies with premiums under $50 million had not met those requirements. The aggregate figures for all individual policies studied by the GAO showed that about 60 cents of every premium dollar was returned as benefits or added to reserves.

Of 142 policies studied by the GAO, the loss ratios of most policies were below the Section 1882 targets. However, the loss ratios of both Blue Cross/Blue Shield plans and Prudential Life Insurance usually were above the targets. This is important because these policies are the most frequently purchased. In 1984, the Blue Cross/Blue Shield plans had an aggregate loss ratio of 81.1 percent while the Prudential plans had a loss ratio of 77.9 percent.

While the loss ratio is a useful guideline to determine if the benefit level is adequate, it was not a requirement. Therefore, according to HHS's interpretation of the law, States were not required to monitor loss ratio experience. Furthermore, penalties for Medigap sales abuse have been seen as the prerogative of the States because they primarily are responsible for regulating the insurance industry. All States GAO visited had a formal complaint system, within either the State insurance department or the State department of elderly affairs. These States also monitored the advertising practices of insurance companies. GAO concluded that Section 1882, when combined with State efforts, not only was protecting the elderly against substandard Medigap policies, but also was providing them with information on how to select Medigap policies. This conclusion has been criticized by some consumer organizations, including Consumers Union, who question the compliance of Medigap insurers with the spirit and intent of the law.

Medigap premiums vary depending on the extent of benefits covered (and the allowable charges made by health care providers to provide those benefits), and other factors such as the extent of utilization of health care services by the covered population, administrative costs, insurance company profit, and reserve requirements. In addition, the cost of a plan can vary depending on the age and geographic location of the enrollee. The 1989 HIAA telephone survey mentioned above found that the mean 1989 annual Medigap premium was $718 and the median was $640. However, it is important to note that 1989 Medigap policies offered fewer benefits in prior or subsequent years because of the more extensive coverage offered by the MCCA.

In 1989, the staff of the Subcommittee on Health and Long-Term Care of the House Select Committee on Aging conducted a telephone survey of officials in the State departments of insurance regarding recent Medigap premium increases. The increases in the 44 States responding to the survey ranged from 10 percent to 133 percent. They also found that 73 percent of the 44 States required that

Medigap premium increases for individual policies be formally approved by the State before going into effect.[10]

In preparation for hearing testimony before the Senate Special Committee on Aging, GAO contacted 29 commercial Medigap insurers to obtain their current estimate of their premium changes. As stated in the GAO testimony, 20 companies responded. The average increase in the 1990 premiums over 1989 is estimated to be 19.5 percent, or $11.44 per month. The increases ranged from 5 percent to 51.6 percent. The average monthly premium in 1989 was $58.52 ($702.24 per year); in 1990, it was $69.96, or $839.52 per year.[11]

The Blue Cross and Blue Shield Association estimated the 1990 premium increases for Medigap policies offered by Blue Cross/Blue Shield. The median nongroup annual premium was $576 in 1989; the median increase for 1990 prior to the repeal of MCCA was projected to be 9 percent, or $52. The median 1990 rate increase after the repeal of MCCA was projected to be 29 percent, or $167.

Few surveys have examined Medigap policy benefits. In its June 1989 issue, *Consumer Reports* magazine rated 28 Medigap policies, ranging in price from $500 to $1,300 per year.[12] All of the policies reviewed by *Consumer Reports* covered the inpatient deductible; about 60 percent covered the cost of SNF care after Medicare's 150 days of coverage, less than 50 percent covered the $75 Part B deductible, and half included an outpatient prescription drug benefit.

Although Section 1882 of the Social Security Act was enacted in response to abusive sales practices in Medigap policies sold to the elderly, violations persist. Testimony by consumer groups and others before the House Committee on Energy and Commerce in April 1989 and before the Senate Special Committee on Aging in March 1990 and the Senate Finance Committee in June 1989 and February 1990 cited a variety of abusive sales practices, including: selling policies which duplicate coverage that the customer already has; generating lists of names to sell to insurance agents through ads offering information about Medicare; and "twisting" which occurs when the customer is encouraged to switch or twist old policies for new ones because of higher commissions on new policies.

OBRA 1990 established new standards for Medigap insurance. The legislative history of the development of the legislation and an outline of the new standards are contained in the issues and legislation section of this chapter.

(E) COST AND UTILIZATION OF PRESCRIPTION DRUGS

On January 1, 1991, the outpatient prescription drug benefit of the MCCA was set to go into effect. The drug benefit was designed to protect Medicare-eligible individuals, primarily the elderly and disabled, from the devastating financial impact of expensive prescription drug costs. However, due to a unique mix of political, social, and economic forces (discussed later in this chapter), Congress repealed MCCA in 1989, and with it, the outpatient prescription drug benefit.

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[10] U.S. Congress. House Select Committee on Aging. Subcommittee on Health and Long-Term Care. *Changes in the Costs of Medigap Insruance: A Fifty State Survey.* Committee Print, 101st Congress, 1st Session. Washington, D.C.: Nov. 2, 1989. p. 1-5.

[11] GAO. *Medigap Insurance: Expected 1990 Premiums After Repeal of the Medicare Catastrophic Coverage Act.* Testimony of Janet Shikles before the U.S. Senate Special Committee on Aging. Harrisburg, PA, Jan. 8, 1990. p. 5-6.

[12] "Beyond Medicare." *Consumer Reports,* June 1989, p. 375-391.

The projected cost estimate of the drug benefit, as well as the fear that it was too low an estimate, represented two of a number of significant reasons why Congress repealed the entire program. This is because prescription drug prices at the manufacturer's level in the decade of the 1980's tripled (152 percent versus 58 percent) the general inflation rate and made estimators wary of what the future might bring in terms of increasing costs. It was feared that these price increases might bankrupt the drug program even before it could begin.

(1) Utilization, Cost, and Coverage of Prescription Drugs

Prescription drugs represent only a small part of this Nation's total expenditures on health care services—about 7 percent. This fact, however, has not diverted attention of health care policymakers, corporate executives, and the population at large from the expensive nature of drug products. For those living on fixed incomes, such as the elderly, drugs can be very expensive and force choices among other necessities of life, such as food and clothing. For almost three of four elderly, prescription drugs represent the single largest out-of-pocket health care expenditure. Because of the costs, some elderly taking many medications at the same time are not able to fill all the prescriptions they need because they simply cannot afford them. Other elderly cut costs by only taking half the dose they need, and some cut tablets in half. Clearly, the cost of drugs has jeopardized the health of many elderly who are unable to afford them.

The need to protect the elderly from the high costs of prescription drugs was made evident during the debate about enactment of the MCCA outpatient prescription drug benefit. While extensive public and private insurance coverage exists for elderly health care expenditures related to hospitalization and physician office visits, few health insurance plans for the elderly offer coverage for prescription drugs. In addition, there are usually significant cost sharing provisions for those plans that do, such as high deductibles and copayments. Finally, older Americans consume disproportionate amounts of medications. For example, in 1988, the 12 percent of the Nation's population who are elderly were estimated to account for 34.3 percent of all retail expenditures on prescription drugs, or $9.1 billion. With little private insurance coverage, high per capita utilization, and no Medicare outpatient prescription drug coverage, the elderly will continue to be held captive to these costs.

While most elderly pay for prescription drug costs out-of-pocket, there are two public sources of prescription drug insurance which can pay for some drug costs for the elderly: the Medicaid program and State-based pharmaceutical assistance programs. The Medicaid program, as well as the most significant legislative development in this area, is discussed in Chapter 8 of this report.

(2) Cause of Cost Increases and Continued Congressional Concern

For most elderly without insurance or some type of public assistance to purchase prescription drugs, it is easy to associate the high costs of prescriptions with the neighborhood pharmacist. In analyzing the increasing cost of prescription products purchased by the elderly from their pharmacies, however, it is important to distinguish between increases in drug prices at the manufacturer level and those at the retail or customer level. The primary cause of increased prescription costs to the elderly have been due to manufacturer's price increases for prescription drugs, not due to pharmacist's price increases.

Data from a report released by HCFA (Manufacturers Prices and Pharmacists' Charges for Prescription Drugs, September 1990) indicate that most if not all of the increase in prices of prescriptions at the pharmacy level has been due to the pharmacist passing along to the patient the price increases received from the manufacturer. In fact, pharmacies often have to absorb part of these manufacturer price increases to remain competitive on the basis of price with other community pharmacies, especially deep-discounting chain pharmacies. While prescription drug manufacturer profits hover around the 15 to 18 percent range each year, the average community pharmacist makes an annual average before-tax profit of only 3 percent.

While pharmaceuticals remain the most frequently used medical intervention in the health care system, they are often inaccessible or used inappropriately by the elderly due to their cost. While it may be difficult to determine a direct relationship between rising costs and the proper use of prescription medications, it can be assumed that rising costs exacerbate known problems with access to and compliance typically encountered by the elderly.

As 75 percent of all older Americans list prescription drug expenses as their highest out-of-pocket medical cost and as inflation in this area continues to soar, Congress can be expected to continue its interest in finding ways to more adequately address this issue. Consistent with this interest, the Congress will continue to monitor the impact that lack of public and private insurance coverage is having on the ability of the elderly to have access to high-quality pharmaceutical care. In that vein, there is likely to be additional attempts to protect older Americans from ever-increasing prescription drug costs.

2. Issues and Legislative Actions

(A) CATASTROPHIC HEALTH CARE LEGISLATION

Without question, the most significant health care policy development during the 100th Congress was the enactment of the catastrophic health care law. The MCCA was heralded as the most significant expansion of Medicare since its inception in 1965. Amid a groundswell of public outcry against this new law and, in particular, its financing, the 101st Congress spent the better part of its first session trying to develop alternatives, short of repeal, to the new law. Just over a year after the legislation was enacted, however, the Congress, concluded that it could not be saved in any form and repealed practically every provision of MCCA in the fall of 1989.

(1) Defining Catastrophic Illness

Prior to addressing the shortcomings of public and private health insurance protection against the cost associated with a catastrophic illness, a definition of the term had to be developed. While most agreed that a catastrophic illness could be defined as a major—usually unexpected—financially unmanageable illness, there were varying opinions on what amount of health care expenditure qualifies as a true catastrophic expense. In response, many rather arbitrarily chose a specific figure, for example $2,000, to define a catastrophic health care expenditure. Other health policy analysts advocated the use of a certain percentage of total annual income, for example 10 percent, to obtain a more accurate picture of the number of people who experience catastrophic health care expenses.

While Members of Congress and the administration used every measuring method available to guide them in constructing the catastrophic health legislation, they chose to rely upon a minimum base health care expense figure to set eligibility provisions.

(2) Shortcomings of Current Medicare Coverage

Throughout the last decade, the fact that there are major gaps in catastrophic health care insurance for millions of Americans of all ages has not been questioned significantly. Even with Medicare, the elderly remain susceptible to catastrophic health care costs. Using varying thresholds and percentages of income figures, HHS estimates that as many as 2.1 million elderly (8.1 percent) experienced catastrophic health care expenses in 1987.[13]

Although Medicare provided excellent hospital benefits, coverage for long-term hospital stays (more than 60 days) was limited and left elderly patients vulnerable to catastrophic out-of-pocket expenses. In 1990, after day 60 in a hospital, the Medicare beneficiary is liable for a $157 daily copayment. After day 90, the same beneficiary had to pay $314 a day. At these rates, such expenses quickly can become "catastrophic."

Other non-Medicare-covered expenses that either can be or contribute to becoming catastrophic costs are the expenses associated with long-term nursing home care, outpatient prescription drugs, and physician charges above the Medicare assigned rate. In addition, expenses incurred from optical, dental, and hearing services and products continued to represent a significant out-of-pocket cost burden not covered by Medicare.

Without question, the greatest catastrophic health care expense is that associated with the provision of long-term nursing home care. At an average annual cost of $30,000 a year, nursing home expenses dwarf all other non-Medicare-covered services. One study has estimated that one-third of elderly households would be financially ruined if one family member were to spend 13 weeks in a nursing home. The beneficiary will qualify for Medicaid assistance only after becoming, for all practical purposes, destitute. (Further discussion of this problem can be found in chapter 9.)

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[13] U.S. Library of Congress, Congressional Research Service. Catastrophic Health Insurance: Medicare. Issue Brief No. IB 87106, by Jennifer O'Sullivan, Oct. 30, 1987 (continually updated). Washington, 1987. P. 2, Catastrophic Illness Expenses. Report to the President, Nov. 1986.

Although long-term nursing home care is extremely expensive, and despite the fact that one in four elderly can be expected to require nursing home care at some point in their lives, the likelihood of needing such care pales in comparison to the likelihood of requiring prescription drugs. Every year, 75 percent of all older Americans consume prescription drugs. For many elderly, the cost of these non-Medicare-covered outpatient prescription drugs can run into the hundreds, and even thousands, of dollars per year. In fact, one in five elderly incur medication costs that exceed $500 a year and, as mentioned previously, for three out of four older Americans it represents their highest out-of-pocket costs.

Further, because prescription drug prices have increased at a rate that has almost tripled the general inflation rate in the last 10 years, few insurers offer coverage of prescription drug costs in their Medigap policies. Most, if not all of those policies that continue to offer the benefit have significantly increased their premiums, making it extremely difficult for many elderly to afford the coverage.

Right behind prescription drug expenses, non-Medicare-covered physician charges represent the next highest out-of-pocket liability. Although Medicare reimburses 80 percent of what the program considers a reasonable charge, physicians who do not accept assignment can and do charge more than the program-determined reasonable charge. As a result, Medicare beneficiaries not only are liable for the additional 20 percent of the charge Medicare deems reasonable, but also are liable for any amount over and above the Medicare assigned rate. Per capita out-of-pocket payments for Part B services rose from $194 in 1980 to and estimated $476 in 1990.

Private insurers offering supplemental insurance (Medigap) coverage to the elderly have been hesitant to offer policies that do more than provide protection against the copayments for the limited services that Medicare covers. Consequently, many elderly have found it particularly difficult and/or unaffordable to find policies that cover long-term nursing home and home health care, prescription drugs, and physician costs that are more than the Medicare approved rate. It appears, therefore, that until a significant private and/or public insurance initiative is developed to address these and other shortcomings, the elderly—particularly the low- to middle-income elderly—will continue to live in fear of incurring catastrophic health care costs.

Tens of millions of nonelderly Americans are at least as vulnerable to catastrophic health care costs. In fact, at least 32 million nonelderly Americans do not have insurance, and many millions more are severely underinsured. Despite receiving a great deal of attention in the 1986 HHS catastrophic health care report and in a number of congressional hearings in 1987 and 1988, the lack of health insurance protection of the under-65 population was not significantly addressed in the MCCA or in any legislation that was enacted through 1990.

(3) Administration's Actions to Address Shortcomings

When President Reagan initially mentioned his desire to find ways to better protect Americans against catastrophic health care costs in his 1986 State of the Union Address, he started the ball rolling toward the almost inevitable passage of legislation which begins to accomplish this goal. Although it was not a new issue (many Members of Congress had introduced pertinent legislation in previous sessions), the administration's willingness to move forward on the catastrophic health care front breathed new life into the issue.

In the 1986 State of the Union Address, the President announced that he had directed the Secretary of HHS to study the catastrophic health care issue and develop recommendations to address health insurance shortcomings. Although an encouraging development, many critics were skeptical of what, if anything, would come of this report. However, when the report was released in 1986, most of the critics were pleasantly surprised and praised Secretary Otis Bowen for the scope of the study and the thoughtfulness of the report's recommendations.

The report provided a comprehensive analysis of the shortcomings of current public and private insurance coverage of catastrophic health care legislation. It focused on three vulnerable groups: The elderly who face large out-of-pocket costs associated with lengthy, non-Medicare covered hospital stays for acute illnesses, older Americans who require long-term care, and the vulnerable uninsured and underinsured under-65 population.

Although the analysis of the numerous problems surrounding the lack of long-term care insurance for older Americans and catastrophic health care protection for the under-65 population was impressive, the proposed recommendations to deal with these problems were viewed by many health policy analysts to be inadequate and/or politically unrealistic. For instance, the long-term care proposals were criticized on the grounds that their tax incentives to encourage the further development of private long-term care policies might well benefit the relatively wealthy, but would leave large gaps in protection for middle- to lower-income brackets. Many health policy analysts therefore concluded that the report's recommendations relied too heavily and unrealistically on private long-term care insurance plans and encourage the use of the medical equivalent of individual retirement accounts (IMAs).

Far and away the most widely heralded—and surprising—recommendation was the Secretary's proposal to restructure the Medicare program to include a beneficiary-financed, actuarially sound, acute care catastrophic benefit. This was an unusual departure for an administration official because it represented one of the first Reagan administration health proposals to depart from its customary reliance on the private sector and/or the States to address a critical health care policy need.

Despite the criticism and after much debate within the White House, Secretary Bowen's acute care catastrophic proposal eventually was endorsed by the President and served as the basis not only for the legislation the administration submitted to the Congress, but also for all other catastrophic health care bills as well.

(4) Congressional Response

The Congress, weary and frustrated of its role of spending the better part of a decade trying to control health care costs rather than address health care needs, heartily welcomed Secretary Bowen's report. After a long respite, the administration finally had opened its doors to the possibility of a major health initiative. Members quickly recognized that, regardless of whether the President followed the report with an endorsement for legislation, they could use the report and its recommendations as a vehicle for legislative action. Even prior to the introduction of the administration's bill, Members of Congress quickly scheduled hearings on the catastrophic health care issue and introduced various versions of the legislation.

The House of Representatives moved more rapidly than the Senate in developing, introducing, marking up, and passing the catastrophic legislation. However, the primary debate in both Houses of Congress consistently centered around how the benefit would be financed and whether it would cover prescription drugs. Despite great initial momentum to sign catastrophic health care protection legislation and despite the fact that separate catastrophic health bills were passed in both Chambers of the Congress in 1987, a compromise between the two bills was not achieved until June 1988. The delay was the result of many factors, including concerns about the prescription drug benefit's costs, the fact that many of the catastrophic health care bill's conferees were participating in the budget summit following the October 1987 stock market crash, and the fact that early delays in the process made it clear that there would not be sufficient time to implement the legislation before 1989. Finally, after 18 months of reports, hearings, legislative proposals, and compromising, the Congress passed and the President signed the Medicare Catastrophic Coverage Act on July 1, 1988.

(5) Repeal of MCCA

A large and negative outcry from older Americans followed the passage of MCCA. Seniors raised a variety of issues, including the financing of the new law and the benefits it covered. A great deal of criticism focused on MCCA's financing. Some beneficiaries liable for the supplemental premium (also known as the surtax) objected to the amount they would be required, or thought they would be required, to pay for the new benefits and coverage. Some beneficiaries also objected to the mandatory nature of the program. Noting that MCCA represented the most significant expansion in benefits since the enactment of Medicare, proponents cited the fact that the law filled some very significant program gaps.

While opponents were most vocal in their opposition to the surtax, other objections fueled their movement for repeal of the law. Suggesting that individuals did not need or desire expanded Medicare coverage, critics noted that over three-fourths of Medicare beneficiaries had some health coverage in addition to Medicare. Others argued that the major gap in Medicare—long-term care services—remained and questioned how any benefit could be labeled "catastrophic protection" without such coverage. In addition, some opponents suggested that they would be paying for benefits they would never use. The fact that the new protections would annually benefit only those few (22 percent) unfortunate enough to incur significant out-of-pocket health care costs was not appealing enough to many Americans. Finally, and very significantly, the fact that the financing for the expansion would come solely out of senior's pockets appeared to be a major source of dissatisfaction.

Whatever the reason, sentiment against the new program was clear. By the spring of 1989, it was clear that the Congress would take action to reduce the surtax.

Various alternative approaches to modifying MCCA were considered during the first session of the 101st Congress. Members of the Finance, Ways and Means, and Energy and Commerce Committees worked for months to try to develop a way to avoid total repeal of the law. The Chairman of the Aging Committee, Senator David Pryor, and the ranking member Senator John Heinz worked hard to try to maintain the prescription drug benefit. Others, including Senators Riegle, Durenberger, Kennedy, and McCain proposed ideas for reforming MCCA.

In early October of 1989, during consideration of the FY 1990 budget reconciliation bill, the House approved, by a vote of 360 to 66, an amendment offered by Congressmen Donnelly and Archer to repeal the Medicare provisions and the financing provisions of MCCA. The amendment retained the Medicaid provisions. A substitute amendment, offered by Congressmen Stark, Gradison, and Waxman, was rejected. The Stark, Gradison, Waxman amendment contained provisions to delete the surtax and retain the Part B flat premium. The benefits their amendment retained were mammography, respite care, home health care, hospice, and prescription drugs.

Two days later, the Senate approved legislation offered by Senator McCain. This bill retained the Part A benefit expansions, except for those related to the SNF benefit. It also retained coverage for immunosuppressive and home IV drugs, mammography services, and respite care. It eliminated the surtax and provided for a recalculation of the Part B premium to fund the remaining benefits.

The two varying legislative alternatives were sent to a joint Senate/House conference to work out a compromise. On November 19, the conferees reported the House repeal measure with a few modifications. The Senate rejected this measure twice. However, the House insisted on the conference agreement. On November 22, 1989, both Houses approved the conference report and MCCA was repealed.

Most provisions, including the new Medicare benefits and the financing provisions, were repealed by H.R. 3607. A few provisions were maintained. H.R. 3607 amended the original MCCA procedures for Federal certification of Medigap policies to reflect repeal of catastrophic coverage. Some important Medicaid provisions were retained. The provisions retained included: (1) requiring Medicaid to pay Medicare premiums and cost-sharing charges for Medicare beneficiaries below poverty; (2) the spousal impoverishment provision which, in the case of the institutionalization of one member of a couple, provides protection for a portion of the couple's income and resources for the maintenance needs of the community spouse;

and (3) requiring Medicaid coverage of pregnant women and infants below poverty. H.R. 3607 also retained the requirement for the establishment of the U.S. Bipartisan Commission on Comprehensive Health Care (the Pepper Commission).

(B) MEDICARE SOLVENCY AND COST CONTAINMENT

Controlling expenditures within the Medicare program and looking for ways to assure the program's solvency continue to be among the highest priority issues for both the Congress and the administration. A driving force for Medicare cost containment is the need to assure solvency of the Medicare trust funds.

The supplementary medical insurance (SMI) program is basically term insurance financed from premiums paid by enrollees and from general revenues. When Medicare was established in 1965, the Part B premium was set at an amount that would cover 50 percent of program costs. The Social Security Amendments of 1972 modified this requirement to limit increases in premium amounts to the percentage increase that Social Security beneficiaries received in their cost-of-living adjustment (COLA). Because program costs increased well beyond the inflation rate on which COLAs are based, the portion of program costs covered by the premium declined to less than 25 percent by 1982.

The Tax Equity and Fiscal Responsibility Act of 1982 set the premium at the level necessary to cover 25 percent of program costs through 1986. Subsequently, this provision has been extended each year by the Congress.

In September 1987, HCFA announced that the Part B monthly premium would be increased an unprecedented 38.5 percent in 1988 from $17.90 to $24.80 to meet the 25 percent of program costs requirement. HCFA explained that the three factors influencing the increase were: (1) Earlier projections for 1987 expenditures and utilization (primarily related to costs associated with physician services) under Part B were too low; (2) the Part B program is projected to continue its current rate of growth; and (3) due to a surplus in the Part B trust fund, the 1986 and 1987 monthly premiums were, in effect, discounted as a result of the contingency reserve fund being drawn down.

Congressional hearings to examine the issue found that while the increase was justified and somewhat expected, it was nonetheless overly burdensome to many Medicare beneficiaries, particularly those with low incomes. Although the 1989 premium increased only 12.5 percent (to $27.90, not including the $4 monthly catastrophic premium), no changes were made to ensure that the premium will not increase by a large amount again. Medicare beneficiaries were paying 963 percent more in Part B premium in 1989 ($27.90 + $4 = $31.90/month x 12 months = $382.80) than they were in 1966, when the premium was $36 per year. The 1990 premium increased 4 percent, to $29.

In their 1990 report, the trustees of the SMI trust fund noted concern about the rapid growth of the program, but declared the SMI program actuarially and financially sound.

The Hospital Insurance (HI) program is primarily financed by payroll taxes. Taxes paid by current workers are used to pay benefits for current workers. The introduction of the PPS, along with other factors slowing inflation in the medical marketplace, has given new life to the trust fund.

In the 1988 HI trustees report, the trustees estimated that the HI trust fund would go bankrupt by 2005–08 under intermediate assumption and by 1999 under pessimistic assumptions.[14] The trustees did not issue a report in 1989.

In the 1990 annual report of the Board of Trustees of the Federal Hospital Insurance Trust Fund, the trustees reported that with intermediate economic projections, the present financing schedule for the HI program is sufficient to ensure the payment of benefits until 2003 or 2005. Again, with pessimistic assumptions, they predicted the trust fund would be bankrupt by 1999.

The inadequacy of the present financing schedule of the HI trust fund to ensure its long-term health remains a legitimate concern. Although recent efforts to reduce the costs of health care paid for the HI program have been successful, the actuarial deficit in the HI program and the probability of exhaustion of the trust fund projected by the trustees are cause for congressional concern.

Moreover, because of changing demographics, fewer workers will be available to support each Medicare beneficiary. Today, over four covered workers support each Medicare enrollee. By the middle of the next century, only slightly more than two covered workers will support each enrollee. According to the trustees, however, all but the most optimistic assumptions indicate that there will be insufficient reserves in the HI program even before this major demographic change begins to occur. Therefore, a need to find ways to ensure the same level of benefits to future generations of the elderly continues.

Prior to the enactment of OBRA 1990, the Medicare payroll tax was 1.45 percent for both the employee and the employer up to a maximum level of $51,300 in 1990. OBRA 1990 increased the maximum level subjected to the payroll tax to $125,000. This change, effective in 1991, will significantly increase revenue coming into the Medicare HI trust fund. However, the primary reason for this legislative modification was to reduce the Federal deficit—not to strengthen the HI trust fund.

(C) FISCAL YEAR 1991 BUDGET

President Bush's proposed FY 1991 budget included legislative proposals to save a total of $5.67 billion from the Medicare program. In addition, the President's budget would have added $1.9 billion in FY 1991 Medicare trust fund revenues by mandating program participation by all State and local government employees, some of whom are currently exempt from participation. As usual, the President's budget was met with a great deal of congressional criticism. From both sides of the aisle, the President was urged to cut back on Medicare cuts.

On September 30, 1990, the President and congressional leaders announced a budget summit agreement for FY 1991–95. The agreement proposed a reduction of projected Medicare outlays of at least

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[14] 1987 HI trustees report, p. 55.

$4.6 billion (with $2.85 billion from providers and $1.75 billion from beneficiaries) for FY 1991 and $60 billion over 5 years. Roughly half of the proposed $60 billion in cuts would come from beneficiaries. The budget summit proposal contained increases in the Part B premium and deductible as well as a new clinical lab co-payment. Particularly because over 50 percent of older Americans fall below 200 percent of poverty, many Members of Congress were concerned about the increased out-of-pocket expenditures the provisions of the budget summit would require.

On October 5, amidst much controversy over the budget summit, the House defeated a budget resolution that would have set the framework for implementation of the budget summit agreement. Many saw Medicare cuts as the driving force behind Members' reluctance to support the summit agreement. Subsequently, the Congress passed a new budget resolution that outlined comparable amounts of cuts, but allowed the committees of jurisdiction to craft the specific entitlement and tax changes.

On October 16, the House passed H.R. 5835, the Omnibus Budget Reconciliation Act of 1990. An amended version was passed by the Senate 2 days later. Finally, days before the election, H.R. 5835 was approved by both the House and the Senate. This new law is a 5-year deficit reduction plan designed to reduce Medicare outlays by $3.6 billion in FY 1991 and $44.1 billion over 5 years.

Part A cuts in payments to hospitals total $13.7 billion over 5 years and $1.6 billion in FY 1991. Payments to physicians and others under Part B will be reduced by $1.6 billion in FY 1991 and $14.2 billion over 5 years. Medicare as secondary payer provisions are expected to save $95 million in FY 1991 and $6.3 billion over 5 years. In spite of a lengthy budget debate and deep Medicare cuts, the Congress made some substantial legislative accomplishments in health care. These accomplishments and specific deficit reduction provisions are outlined below.

(D) IMPACT OF THE BUDGET ON MEDICARE BENEFICIARIES

Medicare beneficiaries were not left out of the budget deficit debate or solution. Under the original budget summit proposal, cuts aimed at beneficiaries were severe, totaling $1.75 billion in FY 1991, and nearly $30 billion over 5 years. The majority of the Congress concluded these cuts were too harsh and argued for moderating them. As a result, the beneficiary cuts were reduced and, while the final budget agreement contained increases in the Part B premium and deductible, it did not include the new co-payment on clinical lab fees contained in the budget summit agreement. Beneficiaries will face $350 million more in out-of-pocket costs in 1991 and $10.1 billion over 5 years.

The Part B premium, deductible and coinsurance provisions are estimated to generate an additional $10.9 billion in Medicare revenue over the 5-year period. The Part B deductible, which had not been increased from $75 since 1982, was one focus of changes affecting beneficiaries. Proposals to increase the Part B deductible ranged from $100 to $150. The new Part B deductible will be $100.

Benefits under Part B are partially funded by monthly premiums paid by enrollees. The original budget summit proposal contained a provision to set monthly premiums to 30 percent of program costs ($33.50 in 1991). Congress rejected the proposal and, in OBRA 1990, set the Part B premium as follows: $29.90 in 1991; $31.80 in 1992; $36.60 in 1993; $41.10 in 1994; and, $46.10 in 1995. The premiums, specified in law for the first time, reflect current estimates of the level necessary for premiums to cover 25 percent of program costs through 1995.

OBRA 1990 contained a few small Part B benefit expansions, which is remarkable in the context of a $500 billion deficit reduction package. Beginning in 1991, female beneficiaries will have Medicare coverage up to $55 for a biennial mammogram. The cost of this benefit is estimated to be $140 million in 1991 and $1.2 billion over 5 years. Also, the 210-day limit on hospice care was eliminated.

Other new benefits include Medicare coverage of the cost of injectable drugs for the treatment of osteoporosis and partial hospitalization services in community mental health centers. In addition, Medicare coverage is broadened for federally qualified rural health centers. Medicare beneficiaries also will greatly benefit from changes in regulation of Medigap policies. Those changes are discussed later in this chapter.

(E) QUALITY OF CARE ISSUES/PEER REVIEW ORGANIZATIONS

When Congress enacted Public Law 98-21 establishing Medicare's PPS, there was a general recognition that inherent in the newly structured payment system were incentives to underserve patients and discharge patients prematurely. To ensure against these outcomes, Congress charged peer review organizations (PROs) with monitoring quality of care as well as utilization outcomes.

The Senate Special Committee on Aging has been actively involved in investigating problems regarding the delivery of quality health care under Medicare. The committee's efforts uncovered serious deficiencies related to early hospital discharges, denial of access to needed services, inadequate rights of appeal, pressures on physicians to provide care at a lower level than that which would be considered sound medical practice, limited focus of PRO activities, inadequate post-hospital care, and the lack of adequate data regarding the quality of health care provided under PPS. Related committee activities uncovered serious limitations on the part of the Federal Government to protect beneficiaries from incompetent and dangerous medical practitioners.

As part of the OBRA 1986, the Congress enacted a number of quality of care reforms. Among the new reforms enacted were the written notice to patients of hospital discharge rights, an improved discharge planning process, a study of payments and administratively necessary days, allowance for provider representation of beneficiaries during certain benefit appeals, and a number of PRO improvements including the requirement that PRO's review the quality of care provided.

The Medicare and Medicaid Patient and Program Protection Act was signed into law on August 18, 1987. This law mandatorily excluded from participation in Medicare, Medicaid, Maternal and Child Health Block Grant, and the Social Service Block Grant any medical practitioner (whether an individual or entity) convicted of a criminal offense for neglect or abuse of a patient in connection with the delivery of a health care item or service or a criminal offense relating to delivery of a service under Medicare or a State health care program. Among its other provisions, the law specifies a number of circumstances under which the Secretary of HHS is granted the discretion to exclude providers from participation in State and Federal health care programs, makes provisions for the duration and appeal of such exclusions, allows for civil monetary and criminal penalties, and requires States to develop a system for maintaining statistics on and reporting of action taken against sanctioned providers.

During 1987, congressional interest in the PRO system and its objective of ensuring the delivery of quality health care continued. OBRA 1987 included a number of changes affecting contracting and other aspects of the PRO system. Specifically, the legislation extends initial and renewal PRO contract periods from 2 years to 3 years, and allows the Secretary of HHS to stagger the contract renewal periods.

These changes are expected to foster greater stability in PRO operations, allow for more accurate evaluation of a PRO's performance, and reduce administrative contracting costs. In addition, the 1987 law requires that each PRO offer educational sessions several times each year to hospital staffs regarding review of the hospital's Medicare services, directs PROs (to the extent possible) to provide initial review of psychiatric and physical rehabilitation services by a physician trained in the appropriate field, and requires PROs to consider special problems of delivering care in remote rural areas.

Also included in the OBRA 1987 were PRO provisions which require that: (1) PROs provide reasonable notice and opportunity for discussion of denied claims and that the provider be given 20 days (for discussion and review) before the payment denial would be effective, (2) the HHS Secretary publish in the Federal Register (30 days before the date on which the change takes effect) any new policy or procedure that affects the performance of PRO contract obligations, (3) general criteria and standards used in evaluating PRO fulfillment of contract obligations be published in the Federal Register, and (4) the Secretary of HHS provide documentation to each PRO on its performance in relation to other PROs.

Several PRO provisions were considered by Congress during deliberations on the FY 1990 budget. Major provisions passed by the Congress as part of OBRA 1989 relate to denial of payment for substandard care. The peer review community was concerned about the requirement to simultaneously notify practitioners/providers and patients of denials of payment for substandard care prior to a reconsideration opportunity for providers/practitioners. The new provision allows practitioners and providers the opportunity for reconsideration of a PRO's quality denial determination prior to patient notification. Such reconsideration would be in lieu of any subsequent reconsideration. Also included in the legislation is language specifying the content of the patient notice on quality denials, which will state: "In the judgment of the peer review organization, the medical care received was not acceptable under the Medicare program. The reasons for the denial have been discussed with your physician and hospital."

Another provision included in the 1989 budget reconciliation, advanced by the American Nurses Association, requires that PROs establish procedures for the involvement of health care practitioners who are not doctors of medicine in the review of services provided by members of their profession.

In 1990, some long debated PRO issues were resolved by the Congress. OBRA 1990 changes to the PRO program included: clarification of the willing and able standard; providing for the exchange of information and coordination of review activities between PROs and Medicare carriers; assuring the confidentiality of PRO deliberations; and, clarifying the limits on liability for PROs. Also, the involvement of optometrists and podiatrists in the review of their services was increased.

Also in 1990, the Institute of Medicine released a report outlining the results of a 2-year congressionally mandated study on quality review and assurance in Medicare. The report outlines a redirection for a Medicare quality assurance program. The report recommends to move toward clinical evaluations and patient outcomes, broaden the range of assessments to include services provided in practitioners' offices and other settings in addition to hospitals, and expand the emphasis on professional self-monitoring and internal organizational improvement. In 1991, Congress will hold hearings on these recommendations and consider legislative changes within Medicare's quality assurance program.

(F) ISSUES AFFECTING PHYSICIANS AND OTHER MEDICARE PART B PROVIDERS

Part B supplemental medical insurance (SMI) of the Medicare program has experienced tremendous growth since its inception, in terms of both services delivered and program expenditures. Between FY 1978 and FY 1987, Medicare spending for physicians' services increased at an average annual rate of 16 percent. SMI accounts for about one-third of total Medicare spending, and physician services make up about 75 percent of SMI expenditures. Although their services comprise less than 25 percent of all Medicare spending, physicians actually may influence more than 70 percent of other medical services used by Medicare beneficiaries.[15]

Between 1980 and 1983, Medicare expenditures for physician services increased at an average annual rate (adjusted for inflation) of 12 percent, compared to 6.5 percent for all physician expenditures.[16] In response, Congress froze Medicare fees for participating physicians from 1984 to 1986; the fee freeze was lifted in December 1986 for nonparticipating physicians. The freeze was a qualified success. While the average annual increase in Medicare expenditures for physician services was lower between 1983 and 1986 (9.1 percent) than in previous years, it nonetheless was higher than the annual increase of 7.2 percent for all physician expenditures.

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[15] Physician Payment Review Commission. Medicare Physician Payment: An Agenda for Reform. Washington, U.S. Gov't. Print. Office, 1987, p. 13.

[16] Anderson, Gerald F. and Jane E. Erickson. National Medical Care Spending. Health Affairs, v. 6, no. 3, fall 1987. p. 101.

(1) Physician Payment Reform

From 1984-87 Congress made a number of legislative adjustments to the way Medicare pays physicians. Despite the adjustments, the PPS remained relatively intact, with payments made for each service rendered. These adjustments, designed to stem the dramatic expenditure increases within Part B, were not successful in slowing the increases.

These increases have been the focus of a great deal of attention. Many have suggested that both the individual prices and the unit of payment are inflationary and create price distortions. Others believe that these imbalances created financial incentives that inappropriately influence physicians' decisions about what services to provide, location of their practices, and speciality choice. The Aging Committee released a report in 1988 entitled "Medicare Physician Payment Reform: Issues and Options." This report provides an overview of the current system, as well as options for change to physician payment under Medicare.

As part of OBRA 1989, the Congress established a new payment system for physician services paid for by Medicare. Because of the magnitude of the reforms, the physician payment reform package was the most significant health care legislation enacted in 1989. Its success clearly reflected the work of Senators Rockefeller and Durenberger, as well as Congressmen Stark and Waxman, who pushed hard for enactment in 1989. The administration's support was also crucial to the reform's success.

Under the new system, payments will be made under a fee schedule based on a relative value scale (RVS). An RVS is a method of valuing individual services in relationship to each other. Also included in the new system are annual volume performance standards which are target rates of increase in physician expenditures.

Background.—For several years, Congress and the administration explored a number of options for reforming the physician payment mechanism under Medicare. In 1986, legislation was enacted that required the Secretary, with the advice of the newly established Physician Payment Review Commission (PPRC) to develop a RVS. HHS made an agreement with the Harvard School of Public Health to develop a resource-based RVS (RBRVS). William Hsiao was the principle investigator, and the American Medical Association (AMA) was a subcontractor. The "Hsiao report," presenting the results of Phase I of the study, was released in September 1988.

In 1989, the PPRC released a report containing recommendations for reforms to the PPS. A major recommendation was the establishment of a Medicare fee schedule based on an RVS. This recommendation was based largely on the Hsiao report, though some modifications were suggested. The PPRC, the administration, and others were concerned that the use of an RVS alone would not control physician expenditures. These concerns stemmed from the fact that an RVS, by itself, does not impose limitations on the volume of services. Volume was a concern because, from FY 1978 to FY 1987, 45 percent of the average annual rate of increase in spending for physicians' services were attributable to increases in the volume and intensity of services. Thus, PPRC recommended the use of a national expenditure target (ET). With this target, if total physician expenditures in a year exceeded the ET, the conversion factor in the subsequent year would be reduced.

Many interest groups supported the concept of the RBRVS. Numerous concerns were raised regarding the construction of the fee schedule, however the most controversial component of the PPRC report was the recommendation for the use of an expenditure target. The PPRC characterized the target as a means of encouraging the physician community to respond with practice guidelines and other mechanisms to encourage appropriate delivery patterns. Also, proponents of the ET felt that an overall spending limit was needed, given the uncertainty surrounding the likely changes in volume and mix of services resulting from implementation of an RVS. Opponents of the expenditure target characterized the ET as a means of limiting Medicare expenditures, suggesting that a target set in this manner might not fully cover costs that they feel are reasonable and necessary to meet the health care needs of the elderly. Many of the opponents argued that physicians might respond to such incentives by rationing care.

In response to concerns that an ET closely resembled a mechanism to ration care, a volume performance standard was developed. This standard and other aspects of the reform are outlined below.

After months of debate around ETs and volume performance standards, as well as a host of other issues, the physician payment reform legislation was incorporated into OBRA 1989. This measure was signed into Public Law 101-239 in late 1989.

Fee Schedule.—Beginning in January 1992, the Secretary is required to establish a fee schedule, each year, which establishes payment amounts for all physicians services provided in all fee schedule areas for the year. The law provides for a transition to the fee schedule from 1992-96. The fee schedule amount for a service is equal to the product of: (1) the relative value for the service; (2) the conversion factor for the year; and (3) the geographic adjustment factor for the service for the fee schedule area.

The relative value for each service has three components. The work component is the portion of the resources used that reflects physician time and intensity including activities before and after patient contact. The practice expense component is the portion of the resources used in furnishing the service that reflects the general categories of practice expenses, such as office rent and wages of personnel. The term includes all expenses, excluding malpractice expenses, physician compensation, and physician fringe benefits. The malpractice component is the portion of resources used reflecting malpractice expenses. The Secretary is to develop a method for combining the relative values determined for each component for each service in order to produce a single relative value for the service. And, the Secretary is required to update the relative values at least every 5 years to take into account changes in medical practice, coding changes, new data on relative value components, or the addition of new procedures. The Secretary is required to consult with the PPRC and physician organizations in making updates.

The conversion factor is another component of the fee schedule. The conversion factor for each year is the previous year's conversion factor adjusted by the update for that year. By April 15 each year (beginning in 1991), the Secretary is required to report the recommendations to the Congress on the appropriate update in the conversion factor for all physician services for the following year. After PPRC review, Congress is expected to specify the update. In the absence of congressional action, a uniform default update is to be applied for all services.

The third component of the fee schedule is the geographic adjustment factor for the service for the area. This adjustment factor takes into account practice expense, malpractice expense, and physician work effort in each of the different fee schedule areas compared to the national average.

Medicare Volume Performance Standard Rates of Increase.—Each year a volume performance standard rate of growth is established for physicians service under Medicare. Services included in the standard are all physicians services, other items and services commonly furnished in physician's offices such as clinical diagnostic laboratory tests, or services commonly performed by physician's. The new law specifies that the following factors that must be included in the calculation of the standard for FY 1990: inflation, growth in the beneficiary population, historical changes in the volume and intensity of services, and a performance standard. In subsequent years, the Secretary is to recommend a standard to Congress, and the PPRC is to comment on the recommendation. Congress is expected to specify the standard. In the absence of congressional action, a default performance standard will be used.

Limitation on Beneficiary Liability.—The new physician payment legislation establishes new limits on extra-billing charges by nonparticipating physicians. The new limits are set at a maximum percentage above the recognized payment amount for nonparticipating physicians. In 1991, the limit is 125 percent. Each year the limit will be reduced by 5 percent, until it reaches 115 percent in 1993. However, because the new balance billing limits are going into effect a year earlier than the fee schedule, total receipts for services slated to go up under the fee schedule would actually drop in 1991. In response to this 1-year problem, OBRA 1990 provides for a temporary 1-year increase in extra-billing limits for evaluation and management services. In 1991, the limits for evaluation and management services are set at the lower of the physician's 1990 MAAC or 140 percent (rather than 125 percent) of the Medicare-allowed amount.

In 1992, the law will revert back to its original schedule and the limit will be 120 percent and 115 percent in 1993. For subsequent years, the limiting charge is 115 percent of the recognized payment amount for nonparticipating physicians for the year. Also, the new law requires physicians to accept assignment on all claims for persons who are dually eligible for Medicare and Medicaid.

Monitoring.—The Secretary is required to monitor actual charges of nonparticipating physicians after January 1, 1991. Also, the Secretary is to monitor and report to Congress on any changes in the proportion of services provided by participating physicians, the proportion of services paid on assignment, and the amounts charged above recognized payment amounts. If the Secretary finds that a significant reduction in participation or assignment rates or an increase in balance billing charges, he is required to develop a plan to address the problem and submit recommendations to the Congress. The Secretary is also required to monitor: changes in utilization and access within geographic, population, and the service-related categories; possible sources of inappropriate utilization which contribute to the overall expenditure level; and factors underlying these changes and their interrelationship.

Medical Care Outcomes and Effectiveness Research.—The Agency for Health Care Policy and Research was created by OBRA 1989. One function of this agency, which will have impact on the implementation of physician payment reform, is to coordinate and expand the outcomes and effectiveness research program. This program promotes research with respect to patient outcomes for selected medical treatments and surgical procedures for purposes of assessing their appropriateness, necessity, and effectiveness. The findings emerging from this research will help physicians more appropriately and cost-effectively treat patients. In addition, the availability of at least some medical practice standards will hopefully protect physicians against inappropriate malpractice suits and awards by potentially serving as an affirmative defense.

Impact.—Simulations of the fee schedule suggest that Medicare payments would, on average, increase for medical specialties and decrease for surgical specialties. Also, the fee schedule is expected to change the distribution of payments among geographic areas with physicians in urban areas facing reductions in payments and those in rural areas generally receiving more. Also, with limits on balance billing, beneficiaries' out-of-pocket costs will decrease. Over time, implementation of volume performance standards will stem increases in Medicare expenditures.

(2) OBRA 1990 Modifications to Physician Reimbursement

OBRA 1990 made a number of changes in Medicare payments to physicians. OBRA 1990 includes a provision that reduces payment by 2 percent for all Part B items and services for November and December 1990. Also in OBRA 1990 were reductions in payments for certain categories of services which are expected to be reduced under the new fee schedule and reductions for services identified as overvalued in OBRA 1989. Reductions in payments for anesthesiology, radiology, and pathology services were mandated, though at a lower level than the President proposed. The administration had proposed reducing payments for radiology and anesthesiology services by a maximum of 25 percent in FY 1991. The budget also provides that the program will no longer make a separate payment for a physician's routine interpretation of an electrocardiogram (EKG) performed in conjunction with a visit or consultation.

OBRA 1990 grants an update of 2 percent in 1991 for primary care services only. The prevailing and customary charges of all other services are frozen at the 1990 levels. Current law places limits on physicians' reimbursement in the first and second year of practice in a given locality. The Presidents' budget proposed limits on the Medicare customary charges of new physicians on the grounds that charges of new physicians should not be as high as those of established physicians. This proposal is included in OBRA 1990, and is expanded to cover services of nonphysician practitioners.

To address the problem of extremely low prevailing charges for primary services in certain localities, OBRA 1990 raises the floor on prevailing charges of primary care services to 60 percent of the national average prevailing charge for the service.

(3) Outpatient Services

Since the implementation of prospective payment for inpatient hospital stays, the rate of growth in ambulatory or outpatient surgery on Medicare beneficiaries has rapidly increased. In his FY 1991 budget, the President proposed reducing payments 10 percent across-the-board for certain hospital outpatient department services.

OBRA 1990 reduces payments for hospital outpatient services by 5.8 percent. In addition, payments for ambulatory surgery services and radiology services will be subject to cost limits. And, the rate paid to ambulatory surgery centers for insertion of an intraocular lens following cataract surgery was set at $200 through December 31, 1992. These budget provisions are projected to reduce FY 1991 outlays by $355 million.

(4) Certified Registered Nurse Anesthetists (CRNAs)

OBRA 1990 includes a revision to the payments for services of certified registered nurse anesthetists, phased in over a 6-year period. Payments for nonmedically directed anesthesia services will, by 1996, be consistent with payments estimated for similar services provided by physicians under the Medicare fee schedule. Payments for medically directed CRNA services will also be phased in so that payments in 1995 will be 70 percent of the Medicare fee schedule amount for anesthesia services. The conversion factors for CRNAs will be subject to a cap in each locality equal to the conversion factor for physician anesthesia services. Because CRNAs provide a high percentage of anesthesia services provided in rural areas, this improved reimbursement will benefit Medicare beneficiaries in rural areas. Senators Symms, Pryor, and other members of the Aging Committee and Finance Committee worked hard to improve reimbursement to CRNAs.

(5) Nurse Practitioners

Another provision within the budget reconciliation bill which will increase access to care for Medicare beneficiaries will provide coverage of and direct payment for the services of nurse practitioners and clinical nurse specialists in rural areas. These practitioners can and do play a vital role in providing critical health care services in medically underserved rural areas. It is hoped that this reimbursement revision will attract additional desperately needed nurse personnel to these areas. The success in expanding coverage to these practitioners is largely credited to the hard work of Senator Daschle.

(6) Durable Medical Equipment

Under current law, durable medical equipment is reimbursed on the basis of a fee schedule that delineates six categories of equipment. In the FY 1991 budget, the President proposed three changes in DME reimbursement, including basing payment for rental cap items on average reasonable charges, instead of average submitted charges, to make the basis of payment consistent with the other five categories. The administration also proposed reducing current payments for oxygen and oxygen equipment by 5 percent. The administration's third proposal recommended basing payments for enteral and parenteral nutrition equipment on wholesale and retail price information.

Though OBRA 1990 does not incorporate the administration's DME proposals, it contains a number of other provisions primarily intended to control growth in spending for DME. These provisions include the following: reducing fee schedule reimbursement for transcutaneous electrical nerve stimulators (TENS) by 15 percent and limiting payment for seatlift chairs to only the seatlift mechanism; repealing existing regional limits on fees and replacing them with phased in national "floors" and upper limits; and prohibiting suppliers from distributing partially completed or completed medical necessity forms to beneficiaries and requiring suppliers to obtain prior approval from carriers for items frequently used unnecessarily. Legislation introduced by Senators Pryor and Heinz, which assured that one pair of eyeglasses or contact lenses will be provided following cataract surgery, was also included.

(7) Clinical Laboratory Services

Clinical laboratory services are currently paid on the basis of areawide fee schedules, subject to a nationwide cap equal to 93 percent of the median value of the areawide fee schedules. The President's budget for FY 1991 had proposed to further limit payment to 90 percent of the median for nonprofile tests and 80 percent for profile tests and standardized test packages. Profile tests are done in standardized groupings and are cheaper to perform. The President had also proposed no fee update for tests above the limit. In addition, the President's budget would have required independent clinical laboratories to report charges for the same test when provided to a non-Medicare patient.

OBRA 1990 reduces the nationwide cap of fee schedules from 93 percent to 88 percent of the national median for tests. It also limits fee schedule updates for clinical laboratory services to 2 percent in 1991, 1992, and 1993.

Concerns about the high rates of expenditures for clinical laboratory testing are likely to continue in the 102d Congress. Among proposals likely to be considered is a 1990 Inspector General report which recommended that laboratory fees be rolled into doctors' fees.

OBRA 1989 contained a provision which prohibits physicians from profiting by referring patients to clinical laboratories in which they have invested. Starting January 1, 1992, physicians are prohibited from referring patients to clinical laboratories in which they have a financial interest. Exemptions from this provision are granted to some types of facilities, including hospital ownership, rural providers, and group practices. Medicare providers will be subject to new reporting requirements regarding ownership, including a requirement that entities report on the ownership arrangements employed and the names and provider numbers of all the physician investors.

(G) MEDIGAP INSURANCE

Medigap insurance has been the subject of congressional interest for more than a decade because of abuses in the marketing of such policies, perceptions that enforcement of Medigap standards has been inadequate, confusion of seniors in purchasing such policies, and concerns about the value and cost of such policies. These concerns were addressed in the 101st Congress by a number of hearings as well as legislation introduced by a number of Members. The final outcome of this attention was a comprehensive Medigap reform package included in the budget reconciliation bill.

Having been plagued with fraud and abuse in this industry since the inception of Medicare, the Congress focused much needed attention on this issue. In particular, the ongoing efforts and commitment of Senators Daschle, Pryor, Heinz, Kohl, Baucus, Durenberger, Riegle, and Rockefeller were instrumental in pushing for Medigap reform. In addition, Congressmen Wyden, Dingell, and Stark played leadership roles. The final legislation represents a bipartisan, cooperative effort to craft a reasonable, effective approach to remedying the ills of the Medigap market.

At a March 1990 Aging Committee hearing, the Committee heard about how some of the most vulnerable of our society—the elderly—are victimized by insurance marketing abuses. Also, the Committee received testimony about the use of slick, misleading come-ons that are used to scare or trick vulnerable consumers into buying something of questionable value that they do not need and cannot afford.

Given the understandable confusion many older persons have about their health insurance needs and coverage, as well as their vulnerability to high pressure, and sometimes unscrupulous, sales practices, Senators Pryor, Heinz, and other members of the Aging Committee introduced S. 2189, the Health Insurance Counseling and Assistance Act. This bill was incorporated in OBRA 1990, and will require the Secretary to make grants to States to support or establish health insurance counseling programs. Health insurance counseling was heralded by some as the most significant aspect of the Medigap reform. The other provisions are outlined below.

Simplification of Policies.—Benefit options will be simplified to provide for a core group of benefits, and up to a maximum of nine other groups of defined Medigap packages. The defined core group of benefits will be common to all defined Medigap benefit packages, and all Medigap insurers will be required to offer the core group of benefits. Noncompliance with simplification standards will be subject to a civil monetary penalty not to exceed $25,000.

Uniform Policy Description.—Using uniform language and format, insurers will be required to provide an outline of coverage to facilitate comparisons among Medigap policies and comparisons with Medicare benefits.

Prevention of Duplicate Medigap Coverage.—It will be unlawful for a Medigap policy to be issued unless the seller obtains from the applicant a written, signed statement stating what type of health insurance the applicant has, the source of the health insurance, and whether the applicant is entitled to Medicaid. Also, it will be unlawful to sell or issue a Medigap policy, or health insurance that duplicates a Medigap policy to an individual who has a Medigap policy, unless the individual indicates in writing that the policy replaces an existing policy which will be terminated.

The direct sale of Medigap policies to Medicaid beneficiaries will be prohibited, except in cases where States pay the Medigap premiums for beneficiaries. Noncompliance with these provisions will be subject to civil monetary penalties.

Loss Ratios.—Minimum loss ratios will be increased to 65 percent for individually sold Medigap policies and will be 75 percent for group policies. NAIC will develop a methodology for uniform calculation of actual and projected loss ratios as well as uniform reporting requirements. Policy issuers will be required to provide a refund or a credit against future premiums to assure that loss ratios comply with requirements. Noncompliance with these requirements will be subject to civil monetary penalties.

Renewability, Replacement, and Coverage Continuation, Preexisting Condition and Medical Underwriting Limitations.—Medigap policies will be required to be guaranteed renewable. The issuer will not be permitted to cancel or nonrenew the policy solely on the grounds of the health status of the policyholder. If the Medigap policy is terminated by the group policyholder and is not replaced, the issuer will be required to offer an individual Medigap policy which provides for the continuation of benefits contained in the group policy.

Medigap insurers will be required to offer coverage to individuals, regardless of medical history, for the 6-month period after an applicant turns 65. The working aged will have a 6-month open enrollment period when they first enroll in Medicare Part B. Also, insurers are prohibited from discriminating in the price of the policy, based upon the medical or health status of the policyholder. Violations of medical underwriting provisions will be subject to civil monetary penalties.

Premium Increases.—States must have a process for approving or disapproving proposed premium increases, and establish a policy for holding public hearings prior to approval of premium increases.

Enforcement of Standards.—No policy may be sold or issued unless the policy is sold or issued in a State with an approved regulatory program, or is certified by the Secretary. The previously inactive Supplemental Health Insurance Panel will be abolished, and the Secretary will be required to review State regulatory programs. States will be required to report to the Secretary on the implementation and enforcement of standards.

If the Secretary finds that a State program no longer meets the standards, the Secretary must provide the State with an opportunity to adopt a plan of correction. If the Secretary makes a final determination that the State program fails to meet the standards, policies sold in such a State are required to be certified by the Secretary.

Promulgation of Regulations.—If the NAIC does not promulgate standards to implement the amendments made by OBRA 1990 within 9 months after the date of enactment, the Secretary will be required to promulgate standards.

State Approval of Policies Sold in the State.—All policies sold in a State, including policies sold through the mail, must be approved by the State in which the policy is issued.

Medicare Select.—The Secretary will be authorized to establish a 3-year demonstration project in up to 15 States which will allow benefits under a lower-cost policy to be restricted to items and services furnished by certain providers, if a policy otherwise complies with Medigap standards.

(H) ISSUES AFFECTING HOME HEALTH CARE

In 1983, Medicare changed the method for paying hospitals from a pay-as-you-go system to a PPS based on pre-determined rates for specific DRGs. Since then, Medicare patients have been sent home from the hospital after shorter stays and in greater need of follow-up health care. At the same time, HCFA has targeted the home health benefit for continual cutbacks, lower payment levels, and narrower interpretation of the scope of the benefit. As a result, more Medicare beneficiaries need home health care at a time when less care is available.

Large Numbers of Medicare patients who are discharged "quicker and sicker" often find post-hospital care unavailable or substandard. The stress on post-hospital services is increasing substantially. In addition, existing hospital discharge planning programs—important mechanisms for assuring that patients are placed in appropriate community settings—are seriously overtaxed under PPS with the result that Medicare patients often received inadequate post-hospital care.

Adding to the problem is the fact that HCFA has sought to reduce nursing home and home health care utilization through administrative denials of reimbursement. While increasing numbers of seriously ill Medicare patients are in need of home health care, home health care denials have nearly tripled since the first quarter of 1983 when PPS was initiated. During this period, the rate of growth in home health services slowed. Medicare-covered visits rose an average of 18 percent from 1980 to 1983, compared to a rise of only 1.3 percent during the period 1983 to 1986. In addition, the number of persons served using home health benefits rose by an average annual rate of growth of 12.2 percent during 1980 to 1983, compared to 5.8 percent for the period 1983 to 1986. Federal policies to restrain beneficiary protections, combined with vague and confusing guidelines for providers, have resulted in reduced access to home health care for older Americans.

Further, HCFA's use of unwritten and unpublished guidelines further limit the Medicare home health benefit. HCFA has repeatedly attempted to eliminate the "waiver of liability" which gives home health agencies critical flexibility in interpreting Medicare rules and regulations so they are not forced to deny access in cases where eligibility is in question. In addition, HCFA has placed limits on home health providers' abilities to appeal decisions denying Medicare beneficiaries home health care and has made it very difficult for Medicare beneficiaries to appeal decisions themselves.

Finally, little attention from the Federal level has focused on the quality of care that home care agencies provide. The evaluation of quality of care by HCFA has focused on the home care agency's organizational form, the facilities and equipment, its staff's credentials, and its fiscal management. These standards tend to measure an agency's capacity to deliver services rather than the quality of the services actually provided.

OBRA 1987 included many of the provisions improving the Medicare home care benefit. The key provisions affecting home care included in OBRA 1987 included strengthened requirements surrounding the publication of HCFA policies, clarification of the definition of "homebound," a demonstration and study on prospective payment for home health care, tougher survey and certification processes, and a home health hotline and investigative unit.

OBRA 1990 included an extension of the waiver of liability for home health agencies, SNFs, and hospices. HCFA created this presumptive status in 1972 as an incentive for providers to accept Medicare patients whose eligibility for services may not have been clear cut. Providers are presumed to have acted in good faith if they demonstrate reasonable knowledge of coverage standards in their submission of claims. In order for providers to be compensated under it, their overall denial rate of claims must be less than 2.5 percent of Medicare claims for home health agencies and hospices, and 5 percent for SNFs. Any provider that exceeds these limits is not reimbursed under the waiver. Over the past serveral years, HCFA has attempted to eliminate the waiver; the OBRA 1990 provision extends it until December 31, 1995.

(I) ISSUES AFFECTING HOSPITALS

In 1990, as in previous years, Medicare hospital payments became a major target for budget-cutting efforts as the Congress sought to meet the deficit reduction targets of the Gramm-Rudman-Hollings law. This fact, combined with efforts to refine the Medicare hospital PPS, created a challenging setting within which the Congress and the administration sought to resolve health policy and deficit reduction demands. Throughout the budget debate, priority was placed on consideration of hospitals which would be particularly vulnerable to further cuts, and in preserving the largest possible hospital payment update within the tight budget constraints.

(1) Transition to National Rates and Increasing DRG Payments

Under PPS, hospitals are paid a predetermined rate based on a physician's diagnosis rather than the former cost-based reimbursement system. Medicare-eligible hospital inpatients are classified into 1 of 470 DRGs, which are based on the patient's diagnosis. DRGs represent the national average cost per case for treating a patient with that particular diagnosis. Separate PPS rates apply depending on whether a hospital is located in a large urban area (over 1 million people, or 970,000 in New England), another urban area, or a rural area, as determined by the Metropolitan Statistical Area (MSA) system maintained by the Office of Management and Budget. These rates are adjusted to account for differences in hospital wage levels. An area wage index is calculated for each MSA; a single wage index is established for all the rural areas in each State.

The national PPS payments rates were phased in over a 4-year period, which was completed in FY 1988. During the transition period, payment rates were based in part on historical, hospital-specific costs and in part on the Federal DRG payment amount. Payments are now based on the Federal DRG amount, with no hospital-specific component. In most areas, the Federal amount is a fully national rate. Although in a few regions with historically higher costs, the Federal amounts will be based in part on regional rates until September 30, 1990. This final transition provision is known as the regional floor. This was extended for 3 years to September 30, 1993, by OBRA 1990. HHS is to report to Congress by June 1993 on a new index to adjust payments for variations in nonlabor inputs. This extension of the regional floor was somewhat controversial in that it mostly benefits hospitals in 11 northeastern and midwestern States.

To determine the total payment to a hospital for a particular DRG, the applicable Federal payment amount is multiplied by the relative weight for that particular DRG. Each of the approximately 470 DRGs has been assigned its own weight which reflects the relative costliness of treating a patient in that DRG compared to the average Medicare patient. OBRA 1989 included a DRG weighting factor reduction of 1.22 percent for discharges of FY 1990. This reduction is the same as one proposed by the Secretary in regulations for 1990. There was not a similar provision in OBRA 1990.

PPS rates are updated each year by the use of an "update factor." Before FY 1988, the same factor was used for all hospitals. For FY 1990-91, separate factors have applied to hospitals according to location. Hospitals in rural areas and large urban areas received larger increases than hospitals in smaller urban areas. Originally, the update factors were supposed to be established by the Secretary of HHS, taking into account the recommendations of the Prospective Payment Assessment Commission (ProPAC). The Secretary was to consider the likely increase in the "market basket index" (MBI), which measures the cost of goods and services purchased by hospitals, but could also make upward or downward adjustments to reflect other factors, such as improved efficiency or adoption of new medical technologies. However, the 99th, 100th and 101st Congresses have postponed the Secretary's authority to set the update factor and instead set them for FY 1986 through FY 1991 directly in legislation.

Hospital payments comprise such a large share of the Medicare program that they were again the major focus of congressional efforts to trim Medicare in 1990. Under the 5-year budget agreement, hospitals will be cut by a total of $13.7 billion—$1.6 billion in FY 1991. The largest portion of that savings—$1.1 billion in FY 1991—comes from changes in the update factor. Payments to hospitals from October 21, 1990 to December 31, 1990, are frozen at FY 1990 rates; effective January 1, 1991, the update factor is equal to the MBI minus 2 percent; for FY 1992, MBI minus 1.6 percent; for FY 1993, MBI minus 1.55 percent, and for FY 1994-95, the full MBI increase.

In October 1989, the President issued a final sequester order under the Balanced Budget and Emergency Deficit Control Act of 1985, thus imposing a 2.1 percent reduction on total Medicare payments. OBRA 1989 extended the sequester reductions for Medicare Part A until December 31, 1989. For payments made after December 31, 1989, OBRA 1989 exempted Medicare Part A services from the continuing governmentwide sequester imposed for the remainder of FY 1990. The net increases in basic inpatient payment rates, effective at the expiration of the temporary sequester on January 1, 1990, were as follows: 4.4 percent for large urban hospitals, 3.75 percent for other urban hospitals, and 8.5 percent for rural hospitals.

(2) Capital Reform

Capital-related costs (including depreciation, leases and rentals, interest, and a separate return on equity payment for proprietary hospitals) are excluded from PPS and are paid on a reasonable cost basis. The passthrough of capital costs has encouraged hospitals to make capital investments whether or not they are justified in terms of the needs of their communities. Moreover, as ProPAC has noted, the passthrough encourages early retirement of assets, promotes insensitivity to interest rates and financing methods, and favors the use of capital over labor resources. In 1984, Medicare paid about $3.2 billion for capital-related costs.

In establishing PPS with the enactment of the Social Security Amendments of 1983 (P.L. 98-21), the Secretary of HHS was originally authorized to develop a method for including capital costs in PPS. Congress has repeatedly postponed this authority. OBRA 1987 required the Secretary to provide payment for capital-related costs in accordance with a PPS, effective for hospital cost reporting periods beginning on or after October 1, 1991, and repealed the Secretary's authority to establish prospective payments for capital before that date.

As the debate to establish PPS rates for capital cost reimbursement continues, Medicare has been paying a rate based on a reduced share of the actual capital costs. OBRA 1989 extended the 15-percent capital-related reduction (established OBRA 1987) for portions of cost reporting periods or discharges occurring beginning on January 1, 1990, and continuing through the remainder of FY 1990. Hospitals received 100 percent of capital costs, subject to the Gramm-Rudman-Hollings budget sequester reduction of 2.1 percent, for the period between October 1, 1989 and December 31, 1989. Sole community hospitals (SCHs) remain exempted from the reduction.

In his FY 1991 budget proposal the President proposed an extension of the current 15-percent reduction in capital payments to rural hospitals, and an increase in the reduction to 25 percent to urban hospitals. OBRA 1990 did not include the administration's proposal; it continues the 15-percent reduction in capital payments to all PPS hospitals for FY 1991. For FY 1992 through FY 1995, OBRA 1990 requires that payments to hospitals for capital related costs be reduced by an amount equal to 10 percent of the amount that otherwise would have been paid on a reasonable cost basis for capital. SCHs, essential access community hospitals and rural primary care hospitals are exempt from this reduction. Because capital reimbursement was slated to increase to 100 percent in FY 1991, this change results in a savings of $810 million in FY 1991 and $4 billion over 5 years.

(3) Periodic Interim Payment (PIP)/Prompt Pay Issues

Those who provide services to Medicare beneficiaries are reimbursed through fiscal intermediaries and carriers. These entities, usually insurance companies such as Blue Cross and Blue Shield, contract with Medicare to handle claims processing, auditing, payment safeguards, and other such responsibilities. Congress approves an annual budget for HCFA to administer the Medicare program which includes within it funds for the carriers and fiscal intermediaries. In recent years, the administrative budget has been tightly controlled as part of efforts to hold down Medicare expenditures.

In response to this situation, Medicare contractors reduced service levels to providers and beneficiaries, claiming that they were receiving inadequate payment to perform the increasing volume and scope of work. Consequently, it is taking more time to process claims and to respond to inquiries.

During 1986, HHS took steps to institutionalize a slow-down in the processing of Medicare payments with the intention of making significant savings in the health care program. Medicare contractors, providers, and Members of Congress responded with vehement opposition to the proposal and the Department recanted. However, the final budget action for fiscal year 1987 included a provision which set minimum standards for timeliness of claims processing: 95 percent of clean claims in fiscal year 1987 were to be paid in not more than 30 days, reduced to 26, 25, and 24 days in subsequent fiscal years.

Prior to fiscal year 1987, HHS regulations allowed for biweekly periodic interim payments (PIP) to providers. These payments were based on the providers projected annual costs divided into 26 equal amounts. Hospitals, home health agencies, and skilled nursing facilities meeting certain criteria were entitled to receive payments on this basis. Under legislative action during 1986, PIP was eliminated for all PPS hospitals with the exception of rural hospitals of 100 beds or less and certain disproportionate share hospitals (hospitals which have a disproportionate share of low-income patients). PIP was to be continued in cases where a hospital could demonstrate it was experiencing significant cash-flow difficulties resulting from operations of the intermediary or from unusual circumstances of the hospital's operation.

OBRA 1987 included several changes in claims processing. As an alternative to achieving deficit reduction savings through lengthening the Medicare claim payment process (as recommended by House budget action), the law instead set a "payment floor," an initial processing period during which claims must be held without payment (a proposal forwarded by the Senate). The payment floor was set at 10 days for the 3-month period beginning July 1, 1988, and 14 days for 1 year beginning October 1, 1988. The legislation prohibits the Secretary of HHS from taking other steps with the specific goal of slowing claims processing or delaying claims payments. In an attempt to reduce the deficit, the Senate proposed elimination of PIP for disproportionate share hospitals. However, this proposal was dropped in the joint Senate/House conference and not included in the OBRA 1987.

OBRA 1989 developed merged hospital guidelines with respect to PIP. In the case of hospitals eligible for PIP that merge with another hospital, the merged hospital would continue to receive PIP payments if the new entity met the disproportionate share adjustment threshold for PIP payments after the merger.

(4) Medical Education

Since its enactment in 1965, Medicare has reimbursed hospitals for its share of the direct costs of approved health professions education programs conducted in hospitals. These direct costs include: (1) Salaries and fringe benefits for residents, faculty, and support staff; (2) the cost of conference and classroom space in the hospital; (3) any costs of additional equipment and supplies; and (4) allocated overhead costs. Physician graduate medical education (residency training) is the most costly component of health professions education paid under Medicare.[17] In addition, Medicare pays teaching hospitals an additional amount, called the indirect adjustment, to cover factors (including indirect teaching costs such as additional tests ordered by residents) that are believed to result in higher costs in teaching hospitals than in nonteaching hospitals.

When the Medicare program was established, Congress made clear its intent that Medicare should support the clinical training of health personnel at least until alternative community-based systems of support were developed. As a result of Medicare payment policies, as well as additional Federal support of the health professions through the National Institutes of Health and Title VII of the Public Health Service Act, a vast network of medical and health profession schools developed throughout the country.

The resulting growth in medical education has helped ease what was once a substantial physician shortage to the point where many now argue that we are in danger of having too many physicians. However, while in the aggregate there may be an excessive amount of physicians, a physician shortage is expected to exist for certain specialty areas such as psychiatry and primary care specialists. Additionally, there is also evidence that there remain a large number of medically underserved areas in the Nation, indicating that excess supply does not directly alleviate maldistribution problems, especially in poor inner-city neighborhoods and remote rural areas.

The legislation authorizing PPS took into account the costs of both direct and indirect medical education. However, within a few years, claims were made that reimbursement for both direct and indirect medical education under Medicare was excessive, and that reductions were warranted.

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[17] U.S. Library of Congress, Congressional Research Service, Background Paper for use of the Members of the Senate Finance Committee on Payments for Medical Education by the Medicare Program. Washington, DC, May 1985.

Direct Medical Education.—Under the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985, the Congress established a PPS for the direct costs of medical education. The Medicare payment to each hospital is equal to the hospital's cost per full-time equivalent (FTE) resident, times the weighted average number of FTE residents, times the percentage of inpatient days attributable to Medicare Part A beneficiaries. Each hospital's per FTE amount is calculated using data from a base year, increased by 1 percent for hospital cost reporting periods beginning July 1, 1985, and updated in subsequent cost reporting periods by the change in the CPI. The number of FTE residents will be calculated at 100 percent after July 1, 1986, only for residents in their initial residency period. For residents not in their initial residency period, the weighting factor will be 75 percent before July 1, 1987, and 50 percent after that date.

The administration's FY 1991 budget proposed revising payments for the direct costs of graduate medical education by basing the payment on a per resident payment derived from the national average of FY 1987 salaries paid to residents, updated by the CPI. The proposal included a system of different weights applied to primary care residents, nonprimary care residents, and nonprimary care residents not in their initial residency period. OBRA 1990 did not include the President's proposal. Rather, it prohibits the Secretary from making any recoupments related to overpayments resulting from the COBRA payment changes for the costs of graduate medical education in FY 1991. The recoupments will then be made over a 4-year period, with one-quarter of the amount due from each hospital payable in each of the 4 fiscal years beginning with 1992.

Indirect Medical Education.—Under the 1983 PPS legislation, Congress doubled the indirect medical education adjustment in order to counteract the potential negative impact that PPS was expected to have on teaching hospitals. These additional payments are made to compensate for the indirect costs associated with the presence of approved graduate medical education programs (or residency training). They may be due to a variety of factors, including the extra demands placed on the hospital staff as a result of the teaching activity or additional tests and procedures that may be ordered by residents. Congressional reports on the PPS authorizing legislation indicate that the indirect medical education payments are also to account for factors not necessarily related to medical education which may increase costs in teaching hospitals, such as more severely ill patients, increased use of diagnostic testing, and higher staff-to-patient ratios.

COBRA provided for additional payments to teaching hospitals based on a formula that increases the Federal portion of the DRG payment from May 1, 1986 to October 1, 1989. The payment increases for each 0.1 increase in the hospital's intern and resident to bed ratio on a curvilinear or variable basis (i.e., the increase in the payment is less than proportional to the increase in the ratio of interns and residents to bed size). OBRA 1987 reduced the adjustment to 7.7 percent effective for hospital discharges occurring on or after October 1, 1988 and before October 1, 1995.

The President's FY 1991 budget proposed to reduce the adjustment factor from 7.7 percent to 4.05 percent on the same curvilinear basis. The estimated savings from this proposal was $1.03 billion. Both ProPAC and the GAO had made similar proposals based on the argument that this lower amount more accurately reflects the estimated effect of teaching programs on a hospital's costs. The Senate's FY 1991 reconciliation proposal included a reduction in the indirect medical education adjustment to an average of 6.8 percent for each 0.1 percent increase in the hospital's ratio of interns to residents. This Senate proposal, however, was not included in OBRA 1990.

(5) Uncompensated Care

The public-private patchwork of health insurance coverage has traditionally afforded basic protection to a majority of Americans. However, in 1987, 31.5 million Americans under the age of 65—nearly 15 percent of the nonelderly population—were without health insurance.[18] The uninsured are disproportionately young; nearly one-half are under 25 years of age, and more than a quarter are children under 18. They are also disproportionately poor or near-poor. About 30 percent are in families with incomes below the Federal poverty level; just over 30 percent have incomes between 100 and 200 percent of poverty.[19] Surprisingly, 300,000 persons over the age of 65 are without insurance of any kind even though the common perception is that all the elderly are taken care of by Medicare and Medicaid.[20]

The number and proportion of the uninsured is increasing substantially. Current Population Survey (CPS) data indicate that the proportion of nonelderly without insurance grew from 14.6 percent in 1979 to 17.5 percent in 1984, and stayed at that level through 1986 despite the economic recovery from the 1982 recession.[21]

Prior to the 1982 recession, the problem of the uninsured was viewed as a problem of the very poor, and those individuals who had seasonal, part-time, or low-skilled jobs, in which employers generally did not provide health insurance coverage. This has changed, however, in recent years. During the last recession, 10.7 million Americans lost their health insurance when they or their family's head of household lost their jobs. Since that time, the system of health care protection has changed radically. Today, more than 80 percent of the uninsured population is employed or lives in families of workers. Cutbacks in Medicaid and other public programs have reduced some of the sources of funding which formerly helped to subsidize health care for America's uninsured. In addition, the changing nature of the health care market, with reforms in reimbursement, heightened competition and the growth of for-profit medicine, is making it increasingly difficult for the uninsured and the underinsured to obtain even emergency access to health care.

Before prospective payment, many hospitals were able to shift the burden of providing high levels of uncompensated care to Medicare and other payers, such as Blue Cross. Under PPS and the continued reduction of Federal payments, as well as tightening reimbursement policies among private payers, hospitals are increasingly reluctant to take patients for whom there is no guarantee of reimbursement. The shrinking number of hospitals that take large numbers of low-income patients argue that such patients are generally sicker and require greater intensity of services. To the extent that these hospitals are bearing a disproportionate burden of such patients, they assert that they should be receiving a reimbursement which reflects this special burden.

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[18] The Pepper Commission. *A Call to Action.* (Washington, DC: U.S. G.P.O.) Sept. 1990, p. 21.

[19] The Pepper Commission, p. 22.

[20] U.S. Congress, Senate Special Committee on Aging, Americans at Risk: Case of the Medically Uninsured. Background paper prepared by the staff. Washington, D.C., June 27, 1985.

[21] The Pepper Commission, p. 22.

Disproportionate share hospitals.—Legislation addressing disproportionate share hospitals (DSHs) was first enacted as a provision in the Tax Equity and Fiscal Responsibility Act of 1982. The Secretary of HHS was required to provide for exemptions from, and adjustments to, the cost limits then in effect for Medicare reimbursement to hsoptials. HCFA did not implement the provision because, as was indicated in regulations, it did not have the data to determine the extent to which special consideration for such hospitals was warranted or the type of provision that might be appropriate. A similar provision for DSHs was included in the Social Security Act Amendments of 1983. Under this act, the Secretary was charged with developing a methodology for a DSH adjustment to the DRG's. Again, HCFA indicated in regulations that it would not implement the provision in fiscal year 1984 or fiscal year 1985 because it did not believe that it had the evidence to justify the adjustment. In Public Law 98-369 (the Deficit Reduction Act of 1984), Congress required the Secretary to develop a definition of disproportionate share hospitals and to identify such hospitals by the end of 1984, which it failed to do.

The special needs of DSHs have been the subject of much debate and have greatly influenced congressional action on a number of issues related to Medicare hospital reimbursement. Special needs could be interpreted to include a broad array of specific problems found in hospitals serving low-income or Medicare patients, ranging from potentially higher costs of treating patients that are more severely ill to the cost of providing uncompensated care. Generally, they have been interpreted more narrowly. Thus, the costs of additional services and more costly services that may be required to meet the needs of low-income or Medicare patients would be included only to the extent that such costs result in higher Medicare operating costs per case in hospitals serving disproportionate numbers of such patients. Moreover, additional payments to hospitals under Medicare for such costs as uncompensated care have been excluded, usually on the grounds that Section 1861(v) of the Social Security Act specifically prohibits Medicare from paying for the costs of services provided to persons not entitled to benefits under the program.[22]

In 1985, ProPAC recommended that a DSH provision be included in fiscal year 1986 PPS rates.[23] Armed with this recommendation, and frustrated by HCFA's inaction, the House Ways and Means Committee decided to develop its own adjustment, and included a provision in its deficit reduction package. In response to a court order from the U.S. District Court for the Northern District of California, resulting from the lawsuit of a small California rural hospital, HCFA published proposed rules implementing the DSH provision on July 1, 1985. However, HCFA made clear that it would award such an adjustment only in extraordinary cases and only after a case-by-case review.

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[22] U.S. Library of Congress, Congressional Research Service. Medicare Payment Provisions for Disproportionate Share Hospitals. Background Paper. Prepared for the use of the Members of the Committee on Finance, Washington, D.C., July 1985.

[23] HHS, Prospective Payment Assessment Commission, Report and Recommendations to the Secretary, Washington, D.C., April 1, 1985.

COBRA required that the disproportionate share adjustment be applied to the Federal portion of the DRG rate for hospitals with a relatively high percentage of low-income patients. Urban hospitals with at least 100 beds received a graduated adjustment from 2.5 to 15 percent, if their disproportionate patient percentage is at least 15 percent. Smaller urban hospitals received an adjustment of 5 percent if their disproportionate patient percentage is at least 40 percent. Rural hosptials received an adjustment of 4 percent if their disproportionate patient percentage is at least 45 percent. The adjustment applied to all discharges after April 30, 1986, and before October 1, 1988. The Technical and Miscellaneous Revenue Act of 1988 continued such payments through September 30, 1995. A hospital's percentage of low-income patients is defined as the hospital's total number of inpatient days attributable to Federal Supplemental Security Income Medicare beneficiaries divided by the total number of Medicare patient days, plus the number of Medicaid patient days divided by the total patient days.

OBRA 1989 increased the Federal portion of DSH's reimbursement rate for urban hospitals with 100 or more beds and rural hospitals with 500 or more beds, by 2.5 percent plus 60 percent (a multiplier of 0.6) of the difference between 15 percent and the hospital's disproportionate patient percentage. Urban hospitals with 100 or more beds and rural hospitals with 500 or more beds that have a disproportionate patient percentage of over 20.2 percent receive a further increase in the adjustment. Hospitals with more than 20.2 percent low-income patients, the payment adjustment is increased by 5.62 percent plus 65 percent (a multiplier of 0.65) of the difference between 20.2 percent and the hospital's percentage of low-income patients.

Rural hospitals classified as rural referral centers receive an adjustment of 4 percent plus 60 percent of the difference between 30 percent and the hospital's percentage of low-income patients. Rural hospitals classified as a SCH receive a 10-percent adjustment. Rural hospitals classified as rural referral centers and SCHs receive the greater of a 10 percent disproportionate share adjustment or an adjustment of 4 percent plus 60 percent of the difference between 30 percent and the hospital's disproportionate patient percentage. The proportionate patient percentage required to qualify or a payment adjustment for a rural hospital with more than 100 beds or a rural hospital classified as an SCH is 30 percent. Hospitals receiving an adjustment based on revenue for indigent care received from State and local governments received a 30 percent disproportionate share adjustment in FY 1990, increased from 25 percent in FY 1989.

OBRA 1990 increases the disproportionate share payment adjustment for urban hospitals with 100 or more beds and rural hospitals with 500 or more beds by increasing the multiplier used in the payment formula on a phased-in basis from FY 1991–95. Hospitals qualifying for the adjustment based on revenue for indigent care received from State or local governments will receive an adjustment of 35 percent. It also makes the disproportionate share adjustment permanent.

(6) Area Wage Index

The area wage index is an important element used in the calculation of DRG payments to hospitals. The wage index was developed to ensure that the DRG payments reflect differences in wages from area to area. To compute the initial wage index, HCFA used hospital wage and employment data maintained by the Bureau of Labor Statistics (BLS) of the Department of Labor. However, it is generally recognized that this data base does not accurately reflect differences among hospitals. The principal limitation of the BLS data—their inability to recognize local differences in the number of part-time workers—was cited by a large number of hospitals, particularly rural midwestern facilities.[24] Under the Deficit Reduction Act of 1984, HCFA was required to report to Congress on a refined wage index which was to be implemented retroactive to October 1983. In 1984, HCFA attempted to obtain better data on wage differences through a survey of hospitals, but the survey was hampered by a low response rate and questionable data quality.

The required report,[25] which was released to Congress in 1985, proposed two alternatives. One wage index was derived from total gross hospital wages, which included salaries and wages for contracted labor, interns and residents, personnel employed in nonhospital cost centers, and hospital-based physicians. The other index excluded several variables from its calculation and was referred to as the adjusted gross index. Later that year, HCFA implemented a new wage index for discharges based on the gross wage data from HCFA's 1984 survey. The rule also provided that the retroactivity required by current law would not come into effect until 1986. This was done to allow time for Congress to reverse the retroactive provision and for HCFA to develop a method to identify retroactive amounts.

In 1986, HCFA implemented a revised wage index, based on 1982 HCFA data which reflected the total hours of employment rather than the number of employees. This wage index was continued into 1987 with minor changes.

In 1987, ProPAC recommended that the Secretary of HHS update the hospital wage data on a regular basis in order to ensure the most accurate wage index possible, and that the data include wage and hour employment information for hospital occupational categories.[26] In September 1987, HCFA published final rules for the Medicare inpatient hospital PPS for fiscal year 1988 which changed the method of computing the national average wage level for use in determining the area wage index. In addition, the regulations adopt a blended wage index which uses a combination of 1982 and 1984 data. These changes resulted in a lower wage index value for all areas relative to the national rate; however, the payment rates were adjusted so that the new index would have no effect on total PPS payments. OBRA 1987 required the Secretary to update the wage index by October 1, 1990, and at least every 3 years after that. OBRA 1989 requires the Secretary to update the area wage index annually, in a budget neutral manner. Because of some problems with the OBRA 1987-mandated October 1, 1990 wage index, OBRA 1990 phases it in over 2 years. In FY 1991, each hospital's wage adjustment will be based on 75 percent 1988 data, and 25 percent 1984 data. In FY 1992, the index will be based on entirely on 1988 wage data.

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[24] HHS, HCFA, Report to Congress on the Hospital Wage Index as required by Section 2316(a) of P.L. 98-369, Washington, DC, March 28, 1985.

[25] Ibid.

[26] ProPAC, Report and Recommendations to the Secretary, U.S. Department of Health and Human Services, April 1, 1987.

(7) Rural Health Care

Access to adequate, appropriate health care services in rural areas was one of the major health care issues of the 101st Congress. Rural hospitals are perceived by many health policy analysts to have a special set of problems that make them more vulnerable to financial difficulties than other hospitals. These problems include fewer hospital admissions, declining lengths of stay, and increasing severity of illness of the patients who are admitted to hospitals. Some of them may be related to cost containment and other changes that have come along with the implementation of Medicare's PPS, which pays rural hospitals less than other hospitals. Others may have arisen because of adverse economic conditions in rural areas. In addition, these hospitals have fewer personnel and specialized services, lower overall occupancy rates, and serve a population more likely to be underinsured as well as older than average. As a result of these differences, many experts believe these hospitals have been more vulnerable to recent Federal health cost containment policies.

As an increasing number of rural hospitals face closure, the debate surrounding the appropriate role of the Federal Government in safeguarding them has become even more contentious. While such hospitals may not be economically efficient, they often play a role in the community that goes beyond the provision of inpatient hospital services. They are often the single largest employer in the area and they help attract primary care physicians who want to be assured that they have access to necessary specialized equipment and staff. In some areas of the United States, the small rural hospital provides the only health care in the area. In these cases, potential patients would be forced to travel long distances, which can prove impossible considering the lack of transportation services in rural communities.

In an attempt to strengthen the rural hospital systems, hospitals are diversifying their services to improve access and delivery of health care. Some rural hospitals are converting a number of post-acute beds to increase out-patient and social services. Other hospitals are entering into multihospital arrangements to help ease their financial strains. These arrangements can include affiliations, shared services, consortium arrangements, contract management, leases, corporated ownership with separate management, and complete ownership. The advantages of joining such arrangements include cost savings from joint purchasing and shared services, certain operating advantages such as increased productivity and lower staffing requirements, and improved access to capital resulting in lower interest costs.[27]

There are a number of features of PPS which have been identified as having an effect on rural hospitals, including the urban/rural DRG payment differential, the wage index adjustment, payments for outlier cases, and the special provisions for sole community providers, referral centers, and hospitals serving a disproportionate share of the poor patients. An issue of primary importance to all hospitals (and particularly rural hospitals) is the amount of annual increase in reimbursement Congress authorizes to PPS hospitals. This increase, known as the update factor, is discussed in greater detail in the next section.

In 1989, 40 rural hospitals were forced to close and as many as 600 face the prospect of closure in the next few years. The average small rural hospital (fewer than 50 beds) is losing money; only 27 percent of the small rural hospitals were breaking even or realizing a profit from patient revenues in 1986. Currently, Medicare reimbursement policies do not adequately meet qualification thresholds for assistance on unusually high cost cases ("outlier" cases), revenue "losers" which are much more difficult for small hospitals to absorb. Furthermore, these policies fail to recognize the vulnerability of low-volume small rural hospitals to a payment system which leaves them at complete risk for fluctuations in admissions and costs.

In addition to the Medicare reimbursement policies, the inadequate numbers of physicians and other health professionals add to the rural health care challenge. The recruitment and retention of physicians into the rural hospital setting is a complex situation involving a great many factors, such as lifestyle, spousal satisfaction, access to new technologies and specialty back up, and of course, reimbursement. Although the supply of physicians continues to grow nationally, the isolated and poor rural areas continue to have difficulty attracting new physicians.

The importance of hospitals that are their community's sole source of care or are so-called "frontier" hospitals is strongly suggested by a recent study of rural residents which found that, largely because of limited resources and access to transportation, only 31 percent of those under age 75 crossed a county line to obtain needed medical care; moreover, a mere 18 percent of those over 75 left their home counties for care. HHS has yet to provide Congress with needed and timely data on what role Medicare and other Federal health care policy decisions have played in terms of maintaining or improving access to medical care in rural areas.

The testimony of expert witnesses in the 1989 hearings resulted in a number of recommendations regarding the current problems facing the rural health care system. The policy recommendations include changes that would:

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[27] Rural Hospitals and Medicare's Prospective Payment System, Background Paper, Prepared for the Use of the Members of the Committee on Finance, May 1986.

(1) Implement a resource-based physician reimbursement system, thus eliminating the urban/rural differential;

(2) Create an optional cost-based reimbursement system for rural hospitals with less than 50 beds;

(3) Develop a hardship fund for hospitals of 50 beds of less that are essential to their community and have a high percentage of Medicare admissions;

(4) Expand the National Health Services Corps and increase Federal funding subsidies for physician extenders and nursing education; and

(5) Define and ensure an orderly and well-planned transition for those rural hospitals that must close. This transition should include an alternative that would ensure that the professional, technical, and transportation components of health care will continue to be available within the community.

A number of provisions of importance to rural hospitals were included in OBRA 1989. These provisions include:

(1) Setting a higher PPS update factor for rural hospitals than for urban hospitals;

(2) Liberalizing the criteria for classifying hospitals as sole community hospitals, a status which qualifies institutions to special treatment under PPS;

(3) Extending the status of current referral centers for 3 additional years, including all hospitals classified as referral centers before October 1, 1989;

(4) Requiring the Secretary to establish a Geographical Review Board for hospitals to direct appeals for a change in classification from rural to urban, or from one urban area to another urban area;

(5) Requiring the Secretary to develop a proposed phase-out plan of the urban-rural differential;

(6) Permitting small rural hospitals classified as Medicare-dependent, with caseloads consisting of 60 percent or more Medicare beneficiaries, to receive payment based on the sole community hospital reimbursement schedule; and

(7) Increasing rural health care transition grants to $25 million for FY 1990 and allowing these grants to be awarded for telecommunications projects.

Another provision of interest to rural health care providers is the Essential Access Community Hospital (EACH) demonstration project, which provides grants in up to seven States for developing a rural health network. This project is based on the premise that for some rural areas, it may make more sense to preserve access to needed services through some other means than operating a full-service acute care hospital. The prototype for these proposals is Montana's program to develop a class of acute care providers called "medical assistance facilities" (MAFs). An MAF is licensed to provide inpatient care while a patient is awaiting transfer to another hospital, or for stays lasting 4 days or less. Under the EACH project, a new type of facility, Rural Primary Care Hospitals (RPCHs), would serve as provider of only limited emergency inpatient care and temporary inpatient care for patients requiring stabilization before discharge or transfer to another hospital. RPCHs would be linked in networks with full service hospitals (EACHs).

OBRA 1990 also contained provisions of importance to rural hospitals. The most significant provision eliminates, over a 5-year phased-in period, the current reimbursement differential between urban and rural hospital PPS rates. For FY 1991, the update factor will be the market basket index (MBI) minus 0.7 percent; FY 1992, MBI minus 0.6 percent; FY 1993, the full MBI increase; FY 1994, MBI plus 1.5 percent; and FY 1995, MBI plus the percentage necessary to close the gap between other urban and rural standardized amounts. In years subsequent to 1995, there will be no difference in the standardized amounts between other urban and rural. In addition, OBRA 1990 increases the disproportionate share adjustment for large rural hospitals with 500 beds or more.

(J) MEDICARE END STAGE RENAL DISEASE PROGRAM

Since 1973, the Medicare program has paid for the medical and related services for over 90 percent of the U.S. population with End Stage Renal Disease. ESRD, or chronic renal failure, occurs when an individual irreversibly loses a sufficient amount of kidney function so that life cannot be sustained without treatment. If the kidneys lose their ability to function, the blood cannot be cleansed of metabolic waste products and the patient will die from toxemia. The primary form of treatment for ESRD is some form of continuous dialysis, where the blood is filtered and the waste products in the blood are removed. Kidney transplantation is also performed on a select number of patients, which obviates the need for continuous dialysis.

In 1988, there were 153,034 ESRD patients in the United States, of which 92 percent (141,816) were covered by Medicare. The average annual cost of treatment of an ESRD patient in 1988 was $35,600, with the Federal Government spending almost $5 billion on ESRD medical services. Those not covered by Medicare are either covered by Medicaid, private insurance (including those who have employer group health insurance coverage for the first year of ESRD, with Medicare becoming the primary insurer after 18 months after diagnosis), are foreign nationals, or are individuals who do not have coverage for services.

The majority of ESRD patients in the United States are elderly. This is because chronic renal failure is usually the result of several long-term chronic diseases, such as hypertension and diabetes. However, ESRD afflicts patients of all age groups.

Dialysis is generally performed on an outpatient basis. About 82 percent of all patients are dialyzed at a hospital-related facility or a free-standing dialysis center, while 18 percent have been trained to performed dialysis at home. Because of the increasing number of elderly patients in this country, the rate of growth in ESRD patients is expected to grow faster than in the past.

(1) Legislative Changes to ESRD Program

OBRA 1990 mandated several important changes in the Medicare ESRD program. First, there is a mandated change in the reimbursement rate for dialysis-related services. Dialysis facilities are paid a capitated rate to provide all medical treatment and services to ESRD patients for each dialysis treatment. Currently, the per-dialysis treatment rate for hospital-based facilities is $129, and for free-standing facilities it is $125. Because of concerns that the rates were insufficient to cover the costs of the facilities providing all required services to ESRD patients, OBRA requires the Secretary to maintain the composite rates in effect on September 30, 1990, increased by $1. This will increase the hospital composite rate to $130 and the free-standing facility rate to $126 after January 1, 1991. Although this increase may seem nominal, it has been many years since the rate has been increased.

OBRA also extends from 12 months to 18 months the period of time during which employer-based health coverage will be the primary payer for ESRD service. Currently, Medicare is a secondary payer to certain employer group health plans for items and services provided to ESRD patients during the first 12 months after becoming eligible for Medicare based on an ESRD diagnosis. After 18 months, Medicare would then become the primary payer for these patients. The GAO is required to study the impact of this change on the individuals eligible for Medicare benefits on the basis of an ESRD diagnosis.

There were also two legislative developments relative to the availability of the recombinant biological erythropoietin (EPO) to ESRD patients. Most ESRD patients suffer from chronic anemia because the failing kidneys are unable to produce the natural hormone EPO. Without EPO, the body cannot produce red blood cells, and the ESRD patient becomes anemic. This results in chronic fatigue and lethargy, and worsens the kidney failure since an insufficient supply of blood gets to the kidney.

In June 1989, the FDA approved the recombinant version of EPO which has proven to be a very effective therapy for the anemia of chronic renal failure. HCFA reimbursement guidelines for EPO, issued shortly after FDA approval, provided that a dialysis facility would receive an add-on payment to the composite rate of $40 for every dose of less than 10,000 units of EPO administered to a dialysis patient. Based on the clinical trials, the average dose was expected to be about 5,000 units per patient. This reimbursement methodology, however, had the effect of reducing the average dose to about 2,600 units, since the initial reimbursement rate did not consider the facility's cost of providing the drug, such as needles and staff administration time.

In addition, the facility had the economic incentive to minimize the per-units administration since they would still recover a $40 payment regardless of the number of units administered. To insure that the facility recovers the total costs of EPO administration, and the patient receives the proper dose of the agent, OBRA 1990 requires that a facility be paid $11 for each 1,000 units of EPO administered.

In another development, Congress amended the Social Security Act to permit self-administration of EPO for home dialysis patients. Because the Social Security Act prohibits HCFA from paying for drugs or biologicals that can be self-administered, patients that would normally dialyze at home could not receive EPO unless they went to a dialysis facility. This proved inconvenient to these patients who had to make adjustments in their dialysis schedules and lifestyles to travel to facilities just to receive EPO. This was a particular problem for dialysis patients that did not live near facilities. OBRA 1990 provides that EPO can be self-administered at home for those patients who are competent to use the biologic without medical or other supervision, subject to methods, standards, and reimbursement rates established by the Secretary of HHS.

Finally, through the efforts of Senator Heinz, ranking member of the Senate Aging Committee, OBRA 1990 requires that the Secretary establish a 3-year demonstration project to evaluate the cost-effectiveness and safety of having trained personnel assist home dialysis patients perform the procedure at home. Such services may allow certain patients who are medically stable, but too frail to perform the procedure themselves at home, to dialyze at home and obviate the need for constant trips to a dialysis center. This demonstration became necessary after a change in reimbursement for home dialysis supplies resulted in Home Intensive Care (HIC)—the largest supplier of these supplies—ceasing to provide uncompensated staff assistance to hundreds of home dialysis patients. While the Health Care Financing Administration was able to make arrangements for most of these patients to receive care in dialysis facilities, a few of them were simply too ill to be safely transported. At Senator Heinz's urging, the Secretary of HHS established an Experimental Authority to pay for staff assistants for these few patients until a permanent solution to their problem could be achieved. This demonstration project will help test the belief that it is safer to the patient and more cost-effective for Medicare to pay for home staff assistants for very ill dialysis patients than to transport them by ambulance to their care center three or more times per week.

(K) HEALTH MAINTENANCE ORGANIZATIONS

During 1982 and 1983, HHS awarded 26 Medicare demonstration program contracts to develop Medicare HMOs. These demonstration projects, which were operational in 21 cities across the country, were implemented to test whether the HMO concept would be effective in holding down Medicare expenditures. HCFA initiated a nationwide program in 1985 providing for the expanded use of HMO's by Medicare.

Two kinds of organizations are eligible to contract with Medicare: federally qualified HMO's under the 1973 HMO Act and competitive medical plans (CMPs) as defined in the TEFRA. For Medicare purposes, the standards that these two kinds of entities must meet to participate in the program are essentially identical. The difference between them is in the way they operate in the private market. The CMP was created to broaden participation and stimulate competition in the medical marketplace.

Under TEFRA, risk-contract HMOs and CMPs receive a fixed, monthly capitation payment for each enrolled beneficiary, and are fully at risk for all Medicare-covered services. In other words, the HMO is responsible for any cost overruns. The beneficiary who enrolls in a risk-contract HMO must receive all medical treatment, except for emergency or urgently needed services, from that HMO. This feature is referred to as the "lock-in" provision. Beneficiaries must pay for services received outside of the plan as well as any services that have not been authorized by the HMO. Neither the HMOs nor Medicare are responsible for the payment of nonemergency out-of-plan services.

The formula used to determine the monthly payment per HMO beneficiary is based on the average adjusted per capita cost (AAPCC), the fee Medicare estimates it would have paid traditional providers (hospitals and fee-for-service physicians) in the same community. HMOs receive 95 percent of the AAPCC, thereby saving Medicare 5 percent on each Medicare HMO enrollee. HMOs also are permitted to charge beneficiaries the usual Medicare deductibles and coinsurance or HMOs may collect an equivalent sum from the beneficiaries in the form of a monthly premium.

Enrolled beneficiaries may receive a portion of the savings achieved by an HMO under its risk contract in the form of additional benefits not otherwise covered by Medicare. Whether savings are available to share with beneficiaries depends on if the HMOs' AAPCC exceeds its average community rate (ACR). The ACR is the HMOs' estimate of what it would charge similar private enrollees for the same set of benefits it will be providing to Medicare beneficiaries under its contract. The ACR is a payment safeguard built into Medicare law to help ensure that HMOs do not retain excessive profits from Medicare's payments. If an HMOs' ACR is less than its estimated average Medicare payment rate, it must use the difference to provide additional benefits to beneficiaries or return the funds to Medicare through reduced premiums.

In November 1990, there were 1,401,967 Medicare beneficiaries enrolled in TEFRA risk or cost contracts with HMOs or CMPs. At that time, 96 risk contracts and 20 cost contracts were in effect. (An additional 596,212 beneficiaries were enrolled in prepaid plans under arrangements other than TEFRA contracts.) Although the number of Medicare HMOs has declined substantially over the past few years, the percentage of Medicare beneficiaries enrolled in a risk or cost contract with HMOs or CMPs has remained steady, at about 4 percent.

(1) Issues Affecting Medicare

The participation of HMOs in the Medicare program represents yet another attempt by the Federal Government to stem rising health care costs. Like all health care cost containment strategies, the challenge facing the Medicare HMO program is to achieve this objective without compromising health care quality. Along those lines, OBRA 1987 contains provisions addressing problems related to post-contract protection of Medicare beneficiaries against health costs not covered by Medicare, quality of care, physician incentive arrangements, and HMO capitation rates. The latter two were further addressed in the budget reconciliation legislation of 1990.

(a) Post-contract protection

An attractive feature of many HMOs is the availability of health care coverage which is more generous than that provided under the combination of Medicare and most supplemental, or Medigap, insurance policies. Accordingly, many beneficiaries join HMOs as an alternative to traditional Medigap policies. However, if an HMO closes or ceases participation in Medicare, a beneficiary may be left facing unanticipated, uncovered health costs. This is a particular problem for beneficiaries with existing health problems because they are unlikely to find alternative Medigap coverage that does not exclude such conditions for a period of several months. As a result, a member of an HMO which has closed may be left totally vulnerable to health care expenditures not covered by Medicare.

In 1987, two events highlighted this potential problem. First, the Florida-based International Medical Corporation, Inc. (IMC), one of the Nation's largest HMOs with about 150,000 Medicare beneficiaries, declared bankruptcy. Second, 29 Medicare HMO's—18 percent of the total—pulled out of the Medicare HMO program.

In the case of IMC, another health care corporation (Humana) assumed responsibility for providing roughly similar services to the IMC enrollees. This arrangement prevented Medicare enrollees from suffering any adverse financial consequences arising from lack of supplemental health insurance. With respect to the HMO withdrawal's from the Medicare program, few beneficiaries were involved due to the small size of the contracts in question.

While these two events could have been much worse in terms of beneficiary impact, they both drove home the point that Medicare enrollees in an HMO are at some risk of sudden supplemental health care costs. To guard against this, Congress included provisions in OBRA 1987 requiring HMOs to ensure that Medicare enrollees are provided with supplemental coverage in the event the HMO ceases to serve such beneficiaries. Additional provisions require HMO's to inform Medicare enrollees of the possibility that its Medicare contract may be cancelled at some future time.

(b) Quality of care

Following a year-long Senate Special Committee on Aging investigation, Senator Heinz released a report in 1987 on HMOs with Medicare risk contracts. It found cases of questionable marketing and biased enrollment practices, involuntary disenrollments, and inadequate medical care, and concluded that HCFA was not fulfilling its monitoring responsibilities. While the findings were preliminary and not intended to be representative of the industry as a whole, groups representing the HMO industry criticized the report for focusing only on grievances within a limited number of HMOs, thereby unfairly and inaccurately magnifying the problems within the Medicare HMO program.

To prevent wrongful practices among HMOs, Congress included provisions in OBRA 1987 to broaden and increase monetary sanctions against HMOs which selectively deny enrollment to a Medicare beneficiary or health care to a Medicare enrollee. A penalty of up to $100,000 was established for engaging in biased enrollment, and existing fines were increased from $10,000 to $25,000 for denying a beneficiary medically necessary services. Similar sanctions were set for charging premiums in excess of the legal amount, involuntarily disenrolling or refusing to re-enroll a beneficiary on the basis of health status.

Despite these beneficiary protections, problems appear to persist in at least some aspects of the Medicare HMO program. A November 1990 series in the Florida Sun about the Humana Gold Plus Plan in Florida (the former IMC) prompted Senator Heinz to request an investigation by the Inspector General of allegations that the plan failed to inform some beneficiaries of the plan's restrictions, used improper enrollment and disenrollment procedures, and improperly denied payment for some members' bills. Another investigation ordered by Senator Heinz in 1988 as a follow-up to some of the findings from the 1987 study is due to be released early in 1991. Preliminary findings indicate serious deficiencies in HCFA's oversight of the internal and external quality assurance activities of the Medicare HMOs, and corrective legislation is expected to be forthcoming early in the 102d Congress.

(c) Physician incentives

HMO contacts with physicians often contain financial incentives to control the volume and cost of services used by enrollees. Such incentives range from limited profit sharing to paying the physician a fixed monthly amount to assume financial responsibility for all of the services used by a group of assigned enrollees. In some contracts, physicians accept financial risk, not only for their own services, but for the services used by their assigned patients when treated by other providers.

Physician incentive arrangements are common in the private sector and have long been used by HMOs and prepaid arrangements as a means to control the volume and costs of services. Although the incentive is clearly to provide less rather than more care under such an arrangement, there are no substantive data to suggest that HMO members have received lower quality care because of these incentives. Nonetheless, critics of physician incentive arrangements believe that in some cases physicians may respond to financial pressure by delaying or denying treatment.

To respond to these concerns, OBRA 1986 banned the use of physician incentive payments by HMOs for their Medicare patients, effective April 1, 1989, and at the same time required a HHS report on acceptable incentive payment systems. OBRA 1987 postponed the effective date of the ban to April 1, 1990, to allow time to fully consider any recommendations in the HHS report, which was subsequently released at the end of 1988.

Most recently, OBRA 1990 lifted the ban on the use of physician incentive arrangements by Medicare HMOs provided that the physician incentive plan used by the HMO does not provide specific payments, directly or indirectly, as an inducement to withhold or limit medically necessary services to a specific patient. In addition, the physician incentive plan cannot place physicians at substantial financial risk (as determined by the Secretary) for services not provided by the physician or by the physician group unless there are appropriate safeguards in place.

(d) HMO-capitation rates

A continuing controversy in the Medicare HMO program surrounds the methodology used to establish the premium rates Medicare pays to risk-contract HMO's. These rates are based on the average adjusted per capita cost (AAPCC)—the Secretary's projection for the coming year of the average Medicare expenditure for providing covered services to beneficiaries who are not enrolled in an HMO or CMP (i.e., those who remain in the fee-for-service Medicare program). The AAPCC accounts for a number of variables, including beneficiary age and sex, disability status, eligibility for welfare benefits, institutional status, and location of the HMO.

Extensive concerns have been expressed by HMO's that the AAPCC is not an accurate reflection of their costs for treating Medicare enrollees, and HMOs have argued vociferously for premium payments set at 100 percent of the AAPCC rather than 95 percent. On the other side of the equation, however, are concerns that Medicare may be overpaying the HMO's because the Medicare beneficiaries that select HMO coverage may be healthier than average.

To develop a payment system which more accurately reflects utilization and costs, Congress included provisions in OBRA 1987 which authorized the Secretary of HHS to establish demonstration projects to test alternative rate-setting methods. The General Accounting Office also was called upon to study the AAPCC and any preferred alternatives. More recently, OBRA 1990 required the Secretary of HHS, in consulation with the HMO Industry, to develop a payment system that is a better predictor of future utilization and costs of services. This may involve adjustments for health status or prior use rates or a new payment methodology and should be in place for 1993 rates.

(e) Prognosis

In light of the urgent need to hold down Medicare costs, the Medicare HMO program holds the promise of providing cost-effective, quality health care. Congress can be expected to continue to adjust the program to assure that cost-effectiveness is not achieved at the expense of Medicare beneficiaries.

(L) MEDICARE FRAUD AND ABUSE

Although it is generally believed that only a small minority of health care providers unfairly profit from Medicare, there is mounting evidence that the program is vulnerable to fraud and abuse. According to the HHS's Office of Inspector general (OIG), an estimated 10 percent of all health care spending is the result of fraudulent billings. Within the Medicare program, this amounts to an estimated $11.3 billion in program losses in 1990 alone.

Both the OIG and the GAO have identified serious weaknesses in the administration of Medicare that open the program to financial abuse. The first of these studies, conducted by the OIG in 1988, investigated approximately 20 percent of all Medicare carriers, private insurance companies that have contracted with HCFA to process Medicare Part B claims.

According to the 1988 OIG study, Medicare carriers have moved away from post-payment review of claims, and no value has been placed by the HCFA on the deterrent value of such reviews. In addition, staffing levels to carry out this function have not kept pace with rising workloads and HCFA has failed to review many carrier's postpayment review activities. At the same time, HCFA gave other carriers full credit for efforts in this area despite known deficiencies.

In the same study, the OIG found that a significant number of carriers often failed to identify substantial fraud and abuse violations, to properly develop fraud cases, and to refer fraud cases to the OIG for prosecution. Carriers referred only a small number of potential fraudulent cases to the OIG for investigation. Of those that were referred, many cases were poorly documented, while many unreferred cases may have warranted criminal or administrative sanctions. Seven out of nine carriers audited closed fraud cases prematurely, failing to make any effort to determine whether there was a pattern of abuse.

Another focus of the OIG's 1988 study was the extent to which HCFA monitored efforts of the carriers to investigate complaints of fraud and abuse raised by Medicare beneficiaries. Out of hundreds, if not thousands of such complaints, the OIG reported that HCFA reviewed annually a total of 10 cases per carrier. Furthermore, the staff who reviewed these cases were insufficiently trained, according to the study. In response to this criticism, HCFA increased the number of claims annually reviewed to 20 per carrier.

In early 1990, GAO launched a comprehensive investigation of the problem of fraud, waste, and abuse within the Medicare program. In June 1990, a representative of GAO testified before the Health Subcommittee of the House Ways and Means Committee on their preliminary finding, which reinforce concerns raised in the OIG study. However, while the OIG study concluded that HCFA needs to place a greater emphasis on program safeguard by carriers, GAO attributes problems in this area to inadequate funding for this purpose.

In support of this finding, GAO testified that Federal funding to Medicare contractors for program safeguards activities has not kept pace with the growth in the number of claims and other related responsibilities. The evidence, to date, leads GAO to conclude that inadequate funding has resulted in a serious deterioration in fraud and abuse controls by Medicare contractors.

For example, GAO found a decrease in the use of computerized screens designed to help identify suspect claims. Among those using these programs, a number of contractor personnel expressed concerns to GAO that health care providers know which screens are used, that cost-saving screens are being turned off, and that Medicare increasingly is vulnerable to abuse as a result. At the same time, GAO documented cuts as high as 50 percent in the size of the claims review staff at Medicare contractors. In addition, GAO found evidence that billions of dollars in costs claimed by small hospitals, skilled nursing homes, and home health agencies are not audited because of insufficient funds. The funding shortfall has occurred in the face of evidence that $11 are saved for every $1 spent on program safeguards.

The final results of GAO's study are expected to be available in 1991. Because of the growing pressures to contain health care costs and cut back on Federal spending, particularly in Medicare, there is little question that Congress anxiously awaits the report and its recommendations.

(1) Beneficiary Role in Controlling Fraud and Abuse

Elderly persons, who spend almost three times per capita more on health care that do other adults, have a particular stake in curbing health care fraud and abuse. Beyond financial harm, unnecessary surgery, tests and services may also pose a health threat.

In 1990, the Senate Special Committee on Aging received numerous reports from elderly Medicare beneficiaries that they had encountered great frustration in trying to get Medicare to follow up on their complaints of provider fraud and abuse. According to these reports, telephone lines to many Medicare contractors were busy for days, and when beneficiaries succeeded in getting through complaints were not investigated. Similarly, written requests for investigations went unanswered.

At the request of the Committee Chairman, Senator David Pryor, and the Ranking Minority Member, Senator John Heinz, the GAO in July of 1990 began an investigation of Medicare's responsiveness to beneficiary complaints of fraudulent and abusive billing by providers. Although the final results of the study are not expected until mid to late 1991, it appears that HCFA does little to ensure that beneficiaries can play a role in helping to identify fraud and abuse in the Medicare program. The Aging Committee plans to hold a hearing on problems in this area in the 102d Congress and to seek ways to ensure older Americans can play an effective role in curbing Medicare fraud and abuse.

(2) Medicare as a Secondary Payer

The Medicare as Secondary Payer (MSP) program requires Medicare to be the secondary payer for beneficiaries who have private employer-sponsored insurance or other forms of liability insurance. Under the law, the private insurance of a Medicare beneficiary must be the health care payer of first resort.

Although the MSP program was enacted in the early 1980's, both the GAO and the HHS' OIG have found that compliance with the law has been dismal. According to GAO, program losses may be as high as $1 billion each year. The OIG estimates are somewhat more conservative, running at $600 million per year. Both GAO and OIG have expressed concerns about a potential conflict of interest Medicare contractors may have with respect to the MSP program. These concerns stem from the fact that Medicare contractors have little incentive to aggressively rectify claims erroneously paid on a primary basis by Medicare when a correct payment would be at the expense of the private insurance side of the Medicare contractor. Further hampering compliance efforts is inadequate funding to the Medicare contractors for this purpose, according to GAO.

More recently, a July 1990 hearing of the Permanent Subcommittee on Investigations of the Senate Governmental Affairs Committee focused on the serious problems in the MSP program. In every segment of the program, shortcomings in program compliance were documented. Witnesses testified that at least one large private health insurer, in an attempt to fraudulently maximize profits, had developed a scheme to illegally forward claims to the Medicare program that the private insurer, by law, was responsible for paying. Evidence was also presented that health care providers were contributing to this problem by failing to obtain information necessary to correctly file claims. At the same time, Subcommittee attention was focused on the disincentives for Medicare contractors to pursue compliance with the law. Although charged with enforcing the law, efforts of HCFA also appear to have fallen short of this goal throughout the 1980's.

In response to these problems, legislation was enacted as part of the OBRA 1989 and 1990 to establish a centralized data pool containing information on the private health insurance status of working Medicare beneficiaries. At present, the data are being submitted by the Internal Revenue Service, the Social Security Administration, and HCFA. It is intended that the data will help to ensure full compliance with the MSP law. In 1991, the Senate Special Committee on Aging will monitor the effectiveness of this new effort.

3. PROGNOSIS

Although the five-year deficit reduction agreement under OBRA 1990 kept beneficiary out-of-pocket costs to a minimum, provider cuts were fairly substantial. A convincing argument can be made that cuts to providers eventually filter their way down to beneficiary in the form of higher costs, reduced access, or lower quality. Continued careful and constant monitoring will be required to make certain that providers do not sacrifice quality care in order to reduce their costs. It is also important to remember that the Medicare program received some benefits under OBRA 1990; for example, the urban-rural hospital differential was eliminated, and some benefit expansions were made.

OBRA 1990 is a five-year budget agreement; in other words, it eliminates the need for an annual budget reconciliation bill. In previous years, Congress made changes and technical corrections to the Medicare program through this process. Because it does not seem likely at this point that there will be a reconciliation bill this year, there are questions as to what legislative vehicle—if any—will be available to Members to make changes to the Medicare program.

In addition to the deficit reduction debate, the lack of protection against long-term care expenses (detailed in the next chapter), the need for addressing the issue of the 37 million plus Americans under the age of 65 who have no health insurance, and the issue of ever-increasing out-of-pocket costs for physician services can be expected to be a major focus of the aging and health policy debate.

Many members believe that before we can address these issues, or ask the American public to pay higher taxes to finance expanded access and availability, health care costs must be contained. The success of the health care cost containment reforms rides on the willingness of patients, providers, and regulators to get the most out of an increasingly lean system. Similarly, the success of new approaches to deal with health care needs of the Nation depends on the ability of policymakers and advocates to develop initiatives that can either significantly alter budget priorities or offer creative, cost-effective health policy alternatives.

Chapter 8

MEDICAID AND LONG-TERM CARE

OVERVIEW

When a chronic illness strikes, most older Americans find that the long-term care services they need are not covered by Medicare, other public programs, or private insurance. In many communities, particularly in rural areas, availability of services can be a problem, regardless of one's financial resources or the coverage offered by various programs. And because these services are often needed over an extended period of time, they can impoverish all but the most affluent. For these and other reasons, long-term care is one of the greatest threats to the financial security of older Americans and their families.

There have been some incremental improvements in long-term care financing and delivery within the last few years, although fundamental change has yet to occur. The reluctance to implement new long-term care initiatives can be attributed to several major factors. The enormous costs of improving access to long-term care services for the elderly tend to deter interest in comprehensive legislative reform, particularly in light of growing budget deficits and competing interests. There is no consensus on a variety of issues surrounding long-term care, such as how to finance it, what services should be provided and by whom, and how to determine eligibility, to name but a few. Finally, the 7.1 million older Americans who need long-term care are a relatively new phenomenon. More Americans are living longer than ever before, and the incidence of chronic illness—and hence the need for long-term care—increases dramatically with advancing age.

Many see the solution to the long-term care problem in the form of a public-private partnership. However, private initiatives alone are unlikely to solve more than a small portion of the problem. The experience of private insurers to date has been generally disappointing. Long-term care insurance policies have not been popular with the American public, especially among those young enough to purchase insurance when it is more affordable. Employers, too, have shown a reluctance to offer a new long-term care benefit, though several insurance companies offer group plans.

There is no one solution to improving the access of the elderly and disabled to comprehensive long-term care services. The only certainty is that any successful improvements in this area will involve the participation of all parties—Federal, State, and local governments, the private sector, and American taxpayers.

As the need for increased access to and affordability of long-term care continues to grow more pressing, there is evidence of heightened congressional interest. Although this interest has yet to be translated into major congressional action, the 101st Congress ended with some movement forward on the issue of long-term care, such as the spousal impoverishment provisions in Medicare Catastrophic Care Act of 1988 (MCCA) and the passage of Senator Rockefeller's legislation to provide home and community-based care to low-income, frail elderly.

One other issue not traditionally thought of as long-term care was partially addressed with the enactment of the Omnibus Budget Reconciliation Act of 1990 (OBRA 1990) (P.L. 101-508). The passage of legislation that will assure the Medicaid program lower prices in its purchase of prescription drugs will expand access to an important long-term care product—medications. Because 7 of the top 10 drug classes used by the elderly are for the treatment of chronic conditions, protections against prescription drug costs represents a true long-term care coverage necessity for older Americans.

The legislation that many believe had the greatest influence on long-term care in the 101st Congress was the repeal of the Medicare Catastrophic Coverage Act of 1988. Although the MCCA provided mostly acute care services, the debate which lead to the eventual repeal of nearly the entire bill in November 1989 had an enormous influence on subsequent discussions of long-term care. An important point of contention was the legislation's lack of comprehensive coverage for long-term care, which many believed were the benefits that beneficiaries most needed and wanted. As a result, efforts to salvage the Bipartisan Commission on Comprehensive Health Care, which was formed under MCCA to study the interrelated issues of long-term care and the under- and uninsured, were successful. Renamed the Pepper Commission after the late Congressman Claude Pepper who was the first chairman of the Commission, its September 1990 report's policy recommendations to address these issues will undoubtedly provide the basis for deliberation and legislation in the 102d Congress and beyond.

A. BACKGROUND

The phrase "long-term care" encompasses a wide array of services offered in a variety of settings ranging from institutional settings (such as nursing homes) to noninstitutional settings such as adult day care centers and a person's own home. Community-based long-term care typically involves a variety of noninstitutional health and social services such as home health care, homemaker, chore and personal services, occupational, physical and speech therapy, adult day care, respite care, friendly visiting, and nutritional and health education. The great majority of long-term care services are provided by family members. Nearly three-quarters of disabled older people not in nursing homes received assistance from relatives and friends in 1989.[1]

Long-term care services provide for the needs of those individuals who are not able to completely care for themselves as a result of chronic illness or physical or mental conditions which result in both functional impairment and physical dependence on others for an extended period of time. Those groups needing long-term care include the elderly and nonelderly disabled, the developmentally disabled (primarily the mentally retarded), and the mentally ill. Older people, because of their high risk of chronic illness that results in disability and functional impairment, are the primary recipients of long-term care in this country.

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[1] The Pepper Commission, U.S. Bipartisan Commission on Comprehensive Health Care. A Call for Action. (Washington, D.C.: GPO), September 1990, p. 97.

The range of chronic illness and conditions resulting in the need for supportive long-term care services is extensive. Unlike acute illnesses, which occur suddenly and are usually resolved in a relatively short period of time, chronic conditions are of an extended duration and may be difficult to treat medically except to maintain the status quo of the patient.

Although chronic conditions can occur at any age, their incidence, particularly as they result in disability, increases with age. According to the 1984 Long-Term Care Survey, about 16.4 percent of persons age 65–74 living in the community have some limitation for which they need assistance, as compared to 47 percent of the persons age 85 years or older. However, the presence of a chronic illness or condition alone does not necessarily result in a need for long-term care, and most older persons are able to live independently in spite of these conditions.

It is when these chronic conditions manifest themselves in functional or activity limitations called limitations in "activities of daily living" (ADLs) that assistance may be required. ADLs include bathing, dressing, eating, getting in and out of bed, and toileting. A second set of measures, called limitations in instrumental activities of daily living (IADLs), reflect a lower level of disability such as difficulties with shopping, cooking, cleaning, and taking medicine.

TABLE 1.—NUMBER, PERCENT DISTRIBUTION, AND RATE OF NURSING HOME RESIDENTS 65 YEARS OF AGE AND OVER BY AGE, SEX, AND RACE: UNITED STATES, 1985

Age, sex, and race	Number of residents	Percent distribution	Number of residents per 1,000 population 65 years and over [1]
Total	1,315,800	100.0	46.1
AGE			
65 to 74 years	212,100	16.1	12.5
75 to 84 years	509,000	38.7	57.7
85 years and over	594,700	45.2	219.4
SEX			
Male	334,000	25.4	29.0
Female	981,000	74.6	57.7
RACE			
White	1,224,900	93.1	47.6
Black	82,000	6.2	35.0
Other	8,900	0.7	20.1

[1] Population data used to compute rates are from—U.S. Bureau of the Census: Estimates of the population of the United States by age, sex, and race, 1980 to 1985 Current Population Reports Series P-25. No. 985. Washington, GPO Apr. 1986.

Source: Chart from Esther Hing, "Use of Nursing Homes by the Elderly: Preliminary Data From the 1985 National Nursing Home Survey," U.S. Department of Health and Human Services, Public Health Service, NCHS Advance Data, No. 135, May 14, 1987.

1. NUMBERS OF PEOPLE RECEIVING LONG-TERM CARE

(A) NURSING HOME CARE

Of the approximately 29 million people age 65 and older in the United States, about 25 percent (7 million) are disabled. Of this group, about 3 million are severely disabled; that is, needing assistance with three or more ADLs. However, less than 20 percent (1.5 million) of the disabled elderly reside in nursing homes. Those with severe disabilities are more likely to be in nursing homes, although more than half of the severely disabled are residing in the community.[2]

On any given day, approximately 5 percent of the elderly population is in a nursing home. These "snapshot" estimates, however, do not provide a true picture of the use of nursing home care among the elderly. Of those age 65 and older in 1990, 36 to 45 percent will use a nursing home before they die.[3] And because the elderly population, particularly those age 85 and older, is growing, nursing homes will be increasingly burdened in the years ahead. With current utilization, the National Center for Health Statistics estimates that the number of elderly persons residing in nursing homes will increase by 58 percent from 1978 to 2003 if constant mortality is assumed, and by more than 115 percent if declining mortality is assumed.[4] Not only will utilization increase, but those in nursing homes will be older and therefore more severely disabled. Researchers at the Brookings Institution estimate that in the years 2016–20, 51 percent of nursing home residents will be age 85 and older, compared to 42 percent in 1986–90.[5]

Analysis of nursing home utilization has found a high degree of variance in length-of-stay patterns among nursing home residents. The majority (75 percent) of persons entering a nursing home stay less than 1 year, and one-third to one-half stay for less than 3 months. Although only 5 percent of all older Americans are likely to be in a nursing home at any given time, those residents are more likely to be very old, female, and white. Residents age 85 and older comprise 45 percent of the nursing home population; 75 percent of elderly residents are female, and 93 percent are white.[6] For women age 85 years and older, their rate of nursing home use per 1,000 population is 248.9, compared to 13.8 per 1,000 for women age 65 to 74, and 66.5 per 1,000 for women age 75 to 84. A similar pattern exists for men, although their utilization rates are much lower. The greater likelihood of elderly white people to live in nursing homes is particularly true in the oldest age group. Of those age 85 and older, 23 percent of white people, compared to 14 percent of black people, reside in nursing homes.[7]

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[2] Rivlin, Alice M. and Joshua M. Wiener, *Caring for the Disabled Elderly: Who Will Pay?*, (Washington, D.C.: The Brookings Institution, 1988), p. 5–6.

[3] The Pepper Commission, p. 92.

[4] Changing Mortality Patterns. Health Services Utilization and Health Care Expenditures: United States 1978–2003, Analytical and Epidemiological Studies Series 3, no. 23, National Center for Health Statistics, Pub. No. (PHS) 83-1407, Sept. 1983. p. 20.

[5] Rivlin and Wiener, p. 11.

[6] National Center for Health Statistics, E. Hing: Use of Nursing Homes by the Elderly: Preliminary Data From the 1985 National Nursing Home Survey. *Advance Data From Vital and Health Statistics*. No. 135. DHHS, Public Health Service. Washington, D.C., May 14, 1987.

[7] National Center for Health Statistics, E. Hing. p. 3.

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(B) HOME- AND COMMUNITY-BASED CARE

For every person age 65 and older residing in a nursing home, there are nearly two times as many living in the community requiring some form of long-term care. According to the Brookings Institution, there were approximately 4.9 million noninstitutionalized elderly residing in the community in 1985, or 18 percent of the over age 65 population, that had limitations in ADLs and IADLs. About two-thirds of the 4.9 million disabled elderly were moderately impaired (less than three ADL limitations).[8] About 850,000 elderly individuals were residing in the community with severe limitations (five or six ADLs).

About 70 percent of the noninstitutionalized disabled elderly relied exclusively on unpaid sources of home- and community-based health care in 1989. Twenty-seven percent received at least some paid care and only 3 percent used paid care only.[9] Of the $9.7 billion spent on home care, $2.1 billion was from out-of-pocket payments, $3.3 billion was from Medicaid, $2.6 billion was from Medicare, and only $600 million was from private insurance.[10]

These figures illustrate the extent to which informal, family caregiving provide for the long-term care needs of the disabled elderly population. One study estimates that more than 27 million unpaid days of informal care are provided each week.[11] The majority of unpaid caregivers are women, usually wives, daughters, or daughters-in-law. Caring for a frail friend or family member places severe emotional, and physical strain—and to a lesser degree, financial strain—on the caregiver. For example, according to the 1982 long-term care survey, 27 percent of caregivers surveyed reported that they were unable to leave their elderly disabled relatives at home alone, and 54 percent reported that their social life or free time had been limited by caregiving. However, only 15 percent said that their parent's care cost more than they could afford. Although most studies have found that worsening health is the primary factor precipitating institutionalization, the stresses associates with caregiving are often cited as a factor contributing to that decision.

Health care policymakers have recognized for some time the need to develop a more equitable balance between institutional and noninstitutional care. Most frail elderly in need of assistance with ADLs would prefer to receive that assistance in their homes. While nursing home care is a necessary part of the long-term care system, many feel it should be an option of last resort.

There is some disagreement whether home and community-based care is less costly than institutional care. Clearly in those instances where round-the-clock care is required, nursing home care is the more economical. However, many frail elderly persons need only intermittent care and assistance, which can be provided less expensively than nursing home care. Further, as the patient's needs for care and assistance change over time—as his or her health improves or worsens—home- and community-based services are more flexible in providing the level of care needed by the patient.[12]

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[8] Rivlin and Wiener, p. 6.

[9] The Pepper Commission, p. 97.

[10] The Pepper Commission, p. 93.

[11] Liu, Korbin and Kenneth Manton, "Disability and Long-Term Care," paper presented at the Methodologies of Forecasting Life and Active LIfe Expectancy Workshop, Bethesda, MD, June 1985, p. 14. As cited in *Caring for the Disabled Elderly* by Alice Rivlin and Joshua Wiener (Washington, D.C.: The Brookings Institution), 1988, p. 5.

2. Coverage and Financing

At least 80 Federal programs assist persons with long-term care problems, either directly or indirectly through cash assistance, in kind transfers, or the provisions of good and services. Most of the public sector's expenditures for long-term care services, however, are for institutional care—primarily for nursing home, and primarily through the Medicaid program.

Data on total national public and private spending for institutional and noninstitutional long-term care are difficult to collect and quantify. According to the Pepper Commission report, total national spending on long-term for all age groups was $52.8 billion in 1988. Of this amount, $43.1 billion was for nursing home care, and $9.7 billion was for home health services (defined as nursing care, home health aides, medical social services, and speech, physical and occupational therapy). In 1988, direct out-of-pocket payments covered 48 percent of the costs of nursing home care ($20.8 billion) and 22 percent of the costs of home health care ($2.1 billion). Private long-term care insurance paid only $1.3 billion of the total costs of nursing home care, and $600 million of the costs of home care.[13]

Nearly one-half of nursing home expenditures were financed by Federal, State, and local governments in 1988. By far the largest portion of public expenditures for nursing home care is financed by the Medicaid program. In 1988, Federal and State Medicaid expenditures for nursing home care amounted to an estimated $19.2 billion—representing approximately 45 percent of total national spending for nursing home care and over 90 percent of public spending.

In contrast, Medicare accounts for only a small portion of the Nation's expenditures for nursing home care. Medicare's 1988 expenditures amounted to $800 million and represented less than 2 percent of national spending and less than 4 percent of public spending for nursing home care.

About one-half of all long-term care costs are financed directly by the elderly and their families. Although the elderly will be better off financially in the coming years, there will also be increased numbers of elderly requiring some form of long-term care. The real incomes of those age 65 to 74 will more than double over the next 30 years because of higher pensions and increased Social Security benefits. For those age 85 and older (the group most at-risk of needing long-term care), however, the future is not so bright. Their income is expected to increase only 17 percent in the same time period. This group is already age 50 or older and therefore will not benefit from higher pension benefits or from the increased participation of women in the work force.

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[12] Burwell, Brian "Home and Community-Based Care Options Under Medicaid," in *Affording Access to Quality Care*, ed. Richard Curtis and Ian Hill, (Washington, D.C.: National Governors Association, 1986).

[13] Pepper Commission, Table 3-1, p. 93.

Further, because long-term care costs are expected to rise more rapidly than the incomes of the old-old (those age 85 and older), those most likely to need long-term care in the future will be worse off financially than the elderly today—even though they will have higher incomes. For example, if nursing home costs rise 5.8 percent per year over the next 30 years, assuming a 4 percent annual general inflation, spending on nursing home care will triple—from $33 billion in 1986-90 to $98 billion in 2016-20.[14]

Following is a discussion of six primary sources of long-term care financing: Medicaid, Medicare, Social Services Block Grants, the Older Americans Act, private long-term care insurance and out-of-pocket payments. Not one of these programs can provide a comprehensive range of long-term care services. Some provided primarily medical care, others focus on supportive or social services. The Medicaid program, for example, has certain income and asset requirements, while the Medicare program does not. Many advocates for the elderly contend that these differences reflect the fragmented and uncoordinated nature of the long-term care system in this country.

(A) MEDICAID

(1) Coverage

Medicaid is a Federal-State entitlement program which provides medical assistance for certain low-income persons. Each State designs and administers its own Medicaid program, setting eligibility and coverage standards within broad Federal guidelines. Although originally intended to provide basic medical services to the poor and disabled, Medicaid has also become the primary source of public funds for nursing home care. Approximateley 90 percent of all public expenditures for nursing home care are paid Medicaid and 50 percent of all nursing home residents use Medicaid as their primary source of payment.[15] Because of the enormous role of the Medicaid program in the financing of nursing home care for the elderly, a section of this chapter provides an in-depth discussion of Medicaid.

Although Medicaid pays primarily for nursing home care, there is some coverage of home- and community-based care, mostly through the Section 2176 waiver program. Congress established these waivers in 1981, giving HHS the authority to waive certain Medicaid requirements to allow the States to broaden coverage to include a range of community-based services for persons who, without such services, would require the level of care provided in a skilled nursing facility or a nursing facility. Services covered under the Section 2176 waiver include case management, homemaker, home health aide, personal care, adult day care, rehabilitation, respite, and others. OBRA 1987 established new home- and community-based services waiver program similar to the Section 2176 program, but the new program is available only to persons over age

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[14] Rivlin and Wiener, p. 12.

[15] National Center for Health Statistics: The 1985 National Nursing Home Survey, data from the National Health Survey. *Vital and Health Statistics*. Series 13, No. 97 HHS Pub. No. (PHS) 89-1758. Public Health Service. Hyattsville, MD, Jan. 1989.

65. While the waivers have been enthusiastically received by the States, there is concern about the administration's support for the Section 2176 waiver program, as is discussed later in this chapter.

(2) Expenditures

Medicaid expenditures for nursing home care in 1988 were approximately $19.2 billion, an increase of 8.5 percent over 1987. This represents approximately 45 percent of total national spending for nursing home care and over 90 percent of public spending for nursing home care.[16]

Medicaid's share of total national expenditures for nursing home care rose steadily since the program's inception in 1965, to a high of 48.6 percent in 1979. In the early 1980's, however, the percentage gradually declined, and appears to have leveled off in the past few years. This decline can be attributed to two factors: cost containment measures, and a shift in the distribution of the Medicaid nursing home population from skilled nursing facilities to less expensive intermediate care facilities (now called "nursing facilities"). From 1977 to 1985, the number of SNF residents increased from 260,000 to 263,000, an increase of 0.9 percent. However, the number of ICF residents increased from 362,600 in 1977 to 488,300 in 1985, an increase of 34.7 percent.[17]

Prescription drug program expenditures accounted for 6.7 percent of total Medicaid program expenditures, totaling $3.7 billion in 1989. Prescription drugs are the fourth highest category of Medicaid spending, ahead of hospital inpatient care, intermediate care facility services, and skilled nursing care; it is the fastest growing portion of the Medicaid health care budget. Although drug coverage is optional, each State Medicaid program offers a prescription drug benefit. The largest drug program is in the State of California, accounting for 12 percent of all Medicaid drug program expenditures. On the average, each State paid on average $222 in 1989 for prescription drugs for each Medicaid recipient.

There are a variety of cost containment measures taken by States to control their Medicaid expenditures. Most States use a form of prospective reimbursement for nursing home care. At least 30 States have instituted formal preadmission screening programs for their Medicaid eligible persons wishing to enter a nursing home. The OBRA 1987 nursing home reforms require all States to screen current and prospective residents for mental illness or mental retardation, based on the premise that nursing homes are inappropriate for such persons. The purpose of these screening programs is to identify people who could be cared for in their own homes or in the community if appropriate services are available, and to assure that nursing home beds are available for those who truly need them. The certificate of need process, in which a provider must apply to the State in order to expand or construct new beds or risk being ineligible for Medicare or Medicaid reimbursement, is seen as a Medicaid cost-containment measure in some States.

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[16] Letsch, Suzanne, Katherine R. Levit, and Daniel R. Waldo. "National Health Expenditures, 1987." *Health Care Financing Review,* Winter 1988, Vol. 10, No. 2. p. 19.

[17] *Medicaid Source Book: Background Data and Analysis.* Report prepared by the Congressional Research Service for the use of the Subcommittee on Health and the Environment, Committee on Energy and Commerce. (Committee Print 100–AA.) Washington, D.C.: GPO, Nov. 1988. p. 470.

Concern about rapidly escalating costs in the Medicaid prescription drug program—due primarily to drug manufacturer's price increases—prompted congressional action in the 2d session of the 101st Congress to limit the growth rate of Medicaid drug program expenditures. The overall rate of inflation in the decade of the 1980's was 58 percent, compared to prescription drug price inflation of 152 percent, almost three times the amount. These drug price increases caused economic hardship for many elderly Americans, as well as the State-based Medicaid drug programs.

(3) Prescription Drug Coverage Building on Medicaid

To provide financial relief for those low-income elderly who are ineligible for Medicaid's outpatient prescription drug benefit, nine States have developed their own pharmaceutical assistance programs (PAPs) for the elderly. These programs have experienced funding problems similar to the Medicaid program, primarily because of manufacturer price inflation in the 1980's. New York was the last State to develop a PAP in 1987, and as of this writing, there is no additional State contemplating the development of a PAP.

These programs provided additional prescription drug coverage for almost 1 million elderly that were ineligible for Medicaid, accounting for almost $470 million in prescription drug expenditures for low-income elderly. However, there were also 7 million additional elderly in these nine States that had no form of prescription drug coverage and many millions more in States that have no PAP.

Although these programs also buy large quantities of prescription drugs each year, they do not receive any discounts or rebates that pharmaceutical manufacturers traditionally give to large-volume purchasers. Lowering the cost of prescription drugs in these PAP programs might enable States to expand the programs to more elderly who have no insurance but who have substantial out-of-pocket costs for prescription drugs.

(B) MEDICARE

(1) Coverage

The Medicare program, which insures almost 98 percent of all older Americans without regard to income or assets, primarily provides acute care coverage for those age 65 and older, particularly hospital and surgical care and accompanying periods of recovery. Medicare does not cover either long-term or custodial care. However, it does cover care in a skilled nursing facility (SNF), home health care, and hospice care in certain circumstances.

The Skilled Nursing Facility Benefit.—In order to receive reimbursement under the Medicare SNF benefit, which is financed under Part A of the Medicare program, a beneficiary must be in need of skilled nursing care on a daily basis for an acute illness.

—medical supplies and equipment (other than drugs and medicines);

—medical services provided by an intern or resident enrolled in a teaching program in a hospital affiliated or under contract with a home health agency; and

—part time or intermittent services provided by a home health aide, as permitted by regulations.

To qualify for home health services, the Medicare beneficiary must be confined to the home and under the care of a physician. In addition, the person must need part time or intermittent skilled nursing care or physical or speech therapy. Services must be provided by a home health agency certified to participate under Medicare, according to a plan of treatment prescribed and reviewed by a physician. The patient is not subject to any cost-sharing, such as deductibles or coinsurance, for covered home care. Although there is no limit on the number of covered visits, program guidelines generally limit daily home health care to 5 days per week for 2 to 3 weeks.

The Hospice Benefit. Medicare also covers a range of home care services for terminally ill beneficiaries. Senators Heinz, Packwood, and Dole and Representatives Gradison and Panetta were instrumental in obtaining Medicare coverage for hospice services in 1982. Hospice benetits are available to beneficiaries with a life expectancy of 6 months or less. Hospice care benefits include nursing care, outpatient drugs, therapy services, medical social services, home health aide services, physician services, counseling, and short-term inpatient care. A Medicare beneficiary who elects hospice care waives entitlement to Medicare benefits related to the treatment of the terminal condition or related conditions, except for the services of the patient's attending physician. Payments to providers for covered services are subject to a cap, which was $9,787 for November 1, 1989 to October 31, 1990, and enrollees are liable for copayments for outpatient drugs and respite care. Coverage for hospice services was subject to a lifetime limit of 210 days, although this limitation was extended by OBRA 1990, if the beneficiary is recertified as terminally ill by a physician.

(2) Expenditures

Medicare expenditures for these services generally have been small. In 1988, Medicare outlays for SNF care were $775 million, which represents 1.9 percent of the total $43.1 billion spent on nursing home care, and less than 1 percent of total Medicare spending.[21] Medicare payments for home health care in 1989 were $2.6 billion, which represents 1,172 visits per 1,000 enrollees, with an average charge of $69 per visit.[22] Expenditures for hospice care in 1989 were $309 million, which represents 89,008 admissions with an average of 48 days of covered care per admission.

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[21] Office of National Cost Estimates. "National Health Expenditures, 1988." *Health Care Financing Review,* Summer, 1990.

[22] Committee on Ways and Means, U.S. House of Representatives. *Background Material and Data on Programs Within the Jurisdiction of the Committee on Ways and Means.* Committee Print 101-29, 101st Congress, 2d Sess. (Washington, D.C.: GPO), June 5, 1990, p. 145.

(C) TITLE XX

(1) Coverage

Title XX of the Social Security Act authorizes reimbursement to States for social services, now distributed through the Social Services Block Grant (SSBG). Among other goals, the SSBG is designed to prevent or reduce inappropriate institutional care by providing for community-based care, and to secure referral or admission for institutional care when other forms of care are inappropriate.

Although the SSBG is the major social services program supported by the Federal Government, its ability to support the long-term care population is limited. Because it provides a variety of social services to a diverse population, the Title XX program has competing demands and can only provide a limited amount of care to the older population.

Prior to 1981, States were required to make public a report on how SSBG funds were to be used, including information on the types of activities to be funded and the characteristics of the individuals to be served. In 1981, these reporting requirements were eliminated, and as a result, data concerning the extent to which Title XX now supports long-term care are very limited. According to a Department of Health and Human Services analysis of the States' fiscal year 1989 pre-expenditure reports, home care services, which may include homemaker, chore, and home management services, were provided to adults and children by 42 States; adult day care services were provided by 26 States.

(2) Expenditures

States receive allotments of SSBG funds on the basis of its population, within a Federal expenditure ceiling. There are no requirements for the use of Title XX funds. States have relative freedom to spend Federal SSBG funds on State-identified service needs. Appropriations in FY 1990 and FY 1991 are $2.8 billion for each year.

(D) THE OLDER AMERICANS ACT

(1) Coverage

The Older Americans Act (OAA) carries a broad mandate to improve the lives of older persons in the areas of income, social services, emotional and physical well-being, housing, employment, civic, cultural, and recreational opportunities. While the OAA funds a wide range of supportive services, in-home services such as homemaker and home health aide, visiting and telephone reassurance, and chore maintenance have been given explicit priority by Congress. Each area agency on aging is required to spend a portion of its supportive services allotment on home care services, with States defining minimum amounts of funding to be spent in each particular area.

The number of home care visits to older persons under the OAA represents only a small fraction of the amount provided under Medicare and Medicaid. The OAA services, however, may be provided without the requirement under Medicare that persons be in need of skilled care and without the strict income and asset tests under the Medicaid program. In some cases, OAA funds may be used to assist persons whose Medicare benefits have been exhausted or who are ineligible for Medicaid.

Congress recognized the growing need for in-home services when it amended the OAA to expand in-home services authorized under Title III. The Older Americans Act Amendments of 1987 (PL 100–175) added a new Part D to Title III, authorizing grants to States for nonmedical in-home services for frail older persons. These services include assistance in such areas as bathing, dressing, eating, mobility, or performance of daily activities such as shopping, cooking, cleaning, or managing money. In-home respite services and adult day care for families, visiting and telephone reassurance, and minor home renovation and repair are additional examples of allowable services under Part D.

(2) Expenditures

Unlike the Title XX program in which States receive a block of funds for unspecified social services, Congress makes separate appropriations of Title III funds for supportive services, congregate and home-delivered nutrition services, and in-home services for the frail elderly. States receive allotments of these funds according to the number of persons age 60 and older in the State as compared to all States. Total FY 1991 appropriations for Title III were $901.8 million, including $361.1 million for congregate nutrition services, $290.8 million for supportive services and senior centers, $87.8 million for home-delivered nutrition services, $149.9 million for USDA commodities, $6.8 million for in-home services for the frail elderly, and $5.4 million for elder abuse prevention and the long-term care ombudsman program. As a result of a provision in the 1987 OAA amendments, AoA in fiscal year 1989 began collecting data on expenditures by service category. AoA program data show that total expenditures for home care and related services under Title III in FY 1989 were as follows: Chore services, $11.4 million; housekeeping, $19.4 million; personal care, $17.5 million; shopping, $687,000; and visiting, $3.5 million.

The total number of meals served under the nutrition program have increased by 45 percent in the years FY 1980 through FY 1989. Home delivered meals accounted for the largest share of that growth, increasing by 174 percent during that period, compared to only 10 percent for congregate meals. Home delivered meals represent about 41 percent of total meals served in FY 1989. There are a number of reasons for this enormous growth in home-delivered meals. Since 1980, funding for home-delivered nutrition services has increased more rapidly than funding for congregate meal services, increasing by 58 percent compared to 30 percent.

The aging of the population is also a factor, because the old-old (those age 85 and older) are more likely to need more in-home services, such as home-delivered meals. States' efforts to develop comprehensive home- and community-based long-term care also have had an impact on this growth, as more and more States are working toward providing services to enable older persons to stay in their homes longer. Finally, earlier discharge of elderly patients from the hospital as a result of the incentives in Medicare's PPS reimbursement system have resulted in an increased demand for home-delivered meals.

(E) PRIVATE INSURANCE

The financing of long-term care through private long-term care insurance has been receiving a great deal of attention recently. This is occurring not only because of growing concerns about public program expenditures, but also because the costs of long-term care represent the largest out-of-pocket health expense for the elderly. To date, however, very few older Americans have purchased this type of coverage. According to the Health Insurance Association of America, as of December 1989, the 118 companies writing long-term care insurance policies had sold more than 1.5 million policies.

There have been numerous problems associated with the development of long-term care insurance that is both affordable and offers broad coverage. In 1987, GAO released a report on the private long-term care insurance market.[23] GAO reviewed 33 policies offered by 25 insurers, accounting for a sizable portion of the policies sold nationwide. There was considerable variation among the policies—for example, the indemnity benefit amounts (fixed dollar amount paid per eligible day of coverage) ranged from less than $10 to $120 per day. Premiums charged varied from $20 to $7,000 per year, offering varying levels of coverage at different ages. Duration of benefits differed widely as well—6 months to 6 years of nursing home care and 10 days to 6 years for home health services.

GAO found that in general, premiums increased with age, and insurers offered indemnity benefits that were not indexed to keep pace with inflation. Most of the policies GAO reviewed contained restrictive clauses (such as requirements that policyholders be admitted to nursing homes within 30 days of hospital discharge) and limitations (such as exclusions from certain diseases) that might prevent some policyholders from collecting benefits.

However, GAO also found that more insurers offered custodial care benefits, and nearly half of the policies reviewed provided benefits for all levels of nursing home care and home care benefits. Most of the policies let consumers choose the length of the waiting period and daily indemnity amounts from among several options. Most of the policies also guaranteed renewability. However, since the insurers who guarantee renewability reserve the right to raise premiums for a class of insured, some elderly policyholders on fixed incomes could be priced out of the market.

More recently, the Washington, D.C.-based United Seniors Health Cooperative released a study in 1988 that examined the coverage provided by 77 private long-term care insurance policies. The study found that most plans had restrictions, such as prior hospitalization or prior skilled care, that severely limited the beneficiary's ability to collect any benefits. The average probability of not collecting benefits from a policy was 61 percent, if the beneficiary were admitted to a nursing home.[24] Furthermore, two-thirds of the plans did not offer benefits that increased with inflation. The most common type of nursing home coverage was a $50 per day indemnity benefit, an amount which the study found to be "grossly inadequate" to meet the expected costs of care in the future.[25]

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[23] GAO. *Long-Term Care Insurance: Coverage Varies Widely in a Developing Market.* GAO/HRD-87-80, Washington, D.C., May 1987.

The researchers also found shortcomings in those plans that offered home health care coverage, particularly the requirement for a prior stay in a nursing home. According to the study, this requirement in effect prevents most policyholders from collecting any benefits. Because eligibility for home care benefits is contingent on one's chances of both entering a nursing home and then returning home, as well as meeting a deductible and often a minimum stay requirement, most policyholders have about a 5 percent probability of collecting benefits.[26]

Over the past 2 years, progress has been made to address some of the concerns raised by the United Seniors Health Cooperative and others. The National Association of Insurance Commissioners (NAIC) have strengthened the Model Act and Regulation to mandate that policies now be guaranteed renewable, not exclude Alzheimer's disease, not require prior hospitalization, provide a summary of coverage, use a pre-existing condition exclusion of not more than 6 months, target at least a 60 percent loss ratio, and not market as a home health care or home care benefit any benefit that has a prior institutionalization requirement. Adoption of the Model Act and Regulation, however, is voluntary, and not all States have adopted all the provisions. These changes also do not address those policies sold before 1989 (when the changes were made), many of which contain restrictions such as prior hospitalization.

A number of barriers have been cited as impediments to the development of long-term care insurance policies. Many insurers are concerned about adverse selection, in which only persons more likely to need long-term care will buy insurance for it. Induced demand—beneficiaries using more services because they have insurance and/or shifting from unpaid to paid providers for their care—is another concern. Further, many people who need long-term care will need it for the remainder of their lives, resulting in an open-ended liability for the insurance company.

In 1985, at congressional request, HHS established a Task Force on Long-Term Health Care Policies. In 1987, the task force released its report to Congress and the Secretary of HHS. The report contained recommendations for encouraging the development of a broad-based market for affordable long-term care policies while providing reasonable protection for consumers. Recommendations included expansion of the market through employer-sponsored long-term care insurance, the creation of tax incentives to encourage participation by both employers and insurance companies, long-term care financing through vested pension funds, the development of new approaches to eligibility requirements for long-term care insurance benefits, and efforts to educate the public on its need for this type of coverage.

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[24] Firman, P. James, William G. Weissert, and Catherine E. Wilson, *Private Long-Term Care Insurance: How Well Is It Meeting Consumer Needs and Public Policy Concerns?* (Washington, D.C.: United Seniors Health Cooperative, 1988), p. 24.

[25] Firman, Weissert, and Wilson, p. 30.

[26] Firman, Weissert, and Wilson, p. 38.

Another approach being considered by some health policymakers to encourage the development of private long-term care insurance is "stop-loss" coverage. This approach would define in advance what an insurance company's cost liability would be. For example, if a private insurer were limited to covering only the first 2 or 3 years of nursing home care, persons would presumably buy an insurance policy to provide that protection. After the covered time period had expired, the Federal Government could then begin to cover the costs of care. This approach would not only limit Federal and private insurance liability, but would also prevent persons from depleting their resources as is currently the case with Medicaid.

The private insurance industry has expressed reservations about this approach, as it does not believe that the Federal Government's covering of the costs of the longest-stay nursing home patients would have a significant impact on premium costs. Rather, they contend that the age of the purchaser has a greater impact on premium costs than duration of coverage. According to the industry, if younger persons purchase policies, the size of the pool sharing the risk is enlarged and reserves can be accumulated over longer periods.

Despite the problems inherent in this area, many believe that significant market developments may occur in the next several years, particularly in the absence of any significant public role in the provision of long-term care. Not only is there growing interest in this area among insurance companies, but many States, faced with mounting Medicaid nursing home expenditures, have expressed interest in having such coverage made more widely available. Although action in the 101st Congress focused primarily on reform of the Medigap insurance market, there was some activity on the issue of long-term care insurance. In May 1990, the Subcommittee on Oversight and Investigations of the House Committee on Energy and Commerce held a hearing on this subject. Testimony focused on the problems facing consumers and insurers in developing and purchasing long-term care insurance. The 102nd Congress will likely see increased efforts among Members to determine the appropriate Federal role in the development and oversight of the private long-term care insurance market.

(F) OUT-OF-POCKET COSTS

While the cost of long-term care represents an increasing share of Federal and State budgets, relatively few older Americans have access to publicly financed services. The cost of nursing home care and home- and community-based care often falls on individuals and their families.

Most older persons and their families pay for nearly one-half of the costs of nursing home care directly out of their own pockets. In 1988, 48 percent of the costs of nursing home care for all age groups ($20.8 billion out of a total of $43.1 billion) were paid out-of-pocket.[27] For those age 65 and older, of the $32.8 billion spent on nursing home care for that age group in 1987, nearly 60 percent was from private sources, most of which were direct out-of-pocket payments.[28] Further, the proportion of total nursing home costs paid out-of-pocket has increased by nearly 14 percent from 1980 to 1987. During that same period, the portion of nursing home costs paid by Medicaid has actually decreased, from 48 percent in 1980 to 44 percent in 1987. While the amount that Medicaid pays for nursing home care has increased 81 percent between 1980 and 1987, the amount paid out-of-pocket increased nearly 125 percent in that same time period.[29] Of the total $9.7 billion spent on home care in the United States in 1988, $2.1 billion, or 22 percent, was paid out-of-pocket.[30] Although home care is generally a less expensive option for the elderly, about 14 percent have out-of-pocket costs from home care that range from $360 to $1,680 per year, depending on the level of disability.[31] These out-of-pocket costs are only for home health care. They do not include other health-related expenses, such as prescription drugs, or the other community-based services needed by many functionally impaired individuals.

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[27] Pepper Commission Report, p. 93.

The cost of community-based care pales when compared to the cost of nursing home care. The price of a year in a nursing home ranges from $24,000 to $50,000; the cost at even the lower end of this range is beyond the resources of many older Americans. Thus, many elderly people must spend their entire savings and become eligible for Medicaid soon after they enter a nursing home. Although there are no national data on the subject on spend-down as it relates to length of stay, there are studies and reports that have examined this issue. According to a 1983 GAO report, between one-quarter and two-thirds of the patients who enter nursing homes as private paying patients subsequently spend down their resources and become eligible for Medicaid.[32] A 1987 study released by the House Select Committee on Aging shows that this spend-down occurs on average within 13 weeks after admission for 70 percent of single older Americans.[33]

The vast majority of the chronically ill and disabled elderly population rely on informal support. In 1989, nearly 75 percent of the severely disabled elderly receiving long-term care at home or in their communities relied solely on family members or other unpaid help. Seven out of ten informal caregivers have the primary responsibility for caring for their disabled friend or family member; one out of three is the sole provider of care.[34]

The burden of caregiving falls overwhelmingly on women. Three-fourths of caregivers are women; one-fourth of women caregivers are between the ages of 65 and 74, and another 10 percent are over age 75, which makes these women vulnerable to chronic illness themselves.[35] Many caregivers are also low-income; one-third report incomes in the poor or near-poor category, and both men and women caregivers are more likely to have family incomes below the poverty line than those persons of the same age with no caregiving responsibilities.[36] One in three caregivers also reports fairly poor health, and among spousal caregiving, the proportion is even greater. More than 4 out of 10 caregivers wives and over one-half of caregiving husbands report fair to poor health.[37]

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[28] Waldo, Daniel R., Sally T. Sonnefeld, David R. McKusick, and Ross H. Arnett III. "Health Expenditures by Age Group, 1977 and 1987." *Health Care Financing Review*, Summer 1989, Vol. 10, No. 4, p. 167.

[29] Letsch, Levit, and Waldo, p. 119.

[30] Congressional Budget Office, 1988.

[31] 1982 National Long-Term Care Survey.

[32] *Medicaid and Nursing Home Care: Cost Increases and the Need for Services Are Creating Problems for the States and the Elderly*. GAO/IPE-84-1, Oct. 21, 1983. pp. 25-26.

[33] U.S. Congress, House of Representatives, Select Committee on Aging, "Long-Term Care and Personal Impoverishment: Seven in Ten Elderly Living Alone Are At Risk." Comm. Pub. 100-631. Washington, DC, October 1987.

[34] Pepper Commission, p. 93.

B. BACKGROUND ON MEDICAID

1. Medicaid Coverage for the Impoverished Aged

(A) AVAILABILITY AND ELIGIBILITY

Medicaid was created by Title XIX of the Social Security Act in 1965. It is a means-tested entitlement program, which means that certain groups of persons (e.g., the aged, blind, disabled, members of families with dependent children, and certain other pregnant women and children) qualify for coverage if their incomes and resources are sufficiently low. Medicaid beneficiaries are entitled to have payment made by the State for covered, medically necessary services. States then receive matching funds from the Federal Government to pay for covered services. There is no Federal limit on payments; allowable claims are matched according to a formula which takes into account a State's per capita income. Therefore, States with a higher per capita income will receive a lower percentage of Federal matching funds and vice versa. The established minimum matching is 50 percent; the highest is 83 percent (although the highest rate in effect in FY 1989 was 80 percent, in the State of Mississippi).

State Medicaid programs are required by Federal law to cover the categorically needy; that is, all persons receiving cash assistance under a welfare program—Aid to Families with Dependent Children (AFDC) and most people receiving assistance under the Supplemental Security Income (SSI) program. Eligible persons must meet the cash assistance program's definition of age, blindness, disability, or membership in a family with dependent children. Therefore, if a person does not fall into one of these categories, he or she is ineligible for Medcaid, regardless of income. Furthermore, people who fall into one of these categories must also meet specific income and resource standards, which vary from State to State.

In addition, States may, at their discretion, cover the optional categorically needy and the medically needy. Optional categorically needy programs extend Medicaid eligibility to those persons who are not receiving cash welfare assistance but who meet certain other criteria. Insofar as the elderly are concerned, optional categorically needy coverage enables persons living in institutions (e.g., nursing homes) to be covered by Medicaid if their incomes are low enough. Medically needy persons are defined as those whose income and resources are large enough to cover daily living expenses, according to income levels set by the State, but are not large enough to pay for their medical care. These State-by-State variations in eligibility can mean persons with identical circumstances may be eligible to receive Medicaid benefits in one State, but not in another.

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[35] Pepper Commission, p. 93.
[36] Pepper Commission, p. 93.
[37] Pepper Commission, p. 94.

A State may also, within Federal guidelines, define its own benefit package. Mandatory services include physicians' and hospital services, and care in a nursing facility (NF). Optional services include prescription drugs, eyeglasses, and services in an intermediate care facility for the mentally retarded (ICF/MR). States may also limit the coverage of all services; e.g., a limit on the number of hospital days. Reimbursement levels vary from State to State as well, so States vary widely in both the breadth and depth of their covered services.

Overall, Medicaid covers less than one-half of the population with incomes below the Federal poverty line. Approximately 41 percent of the poor were covered by Medicaid in 1986; the percentage varied by age, with coverage extended to 52 percent of poor children, 34 percent of poor working age adults, and 31 percent of the poor elderly. However, although the elderly constituted only 14 percent of beneficiaries in fiscal year 1986, they accounted for 35 percent of total Medicaid spending. Conversely, while two-thirds of Medicaid recipients in FY 1988 qualified because they were a member of an AFDC family, these recipients accounted for only 24 percent of program benefits.

Medicaid coverage for the elderly is important because they have greater health care needs than the rest of the population. Despite their greater health needs, they receive 35 percent fewer physician visits, use 29 percent fewer prescription drugs, and are 18 percent less likely to be admitted to a hospital. Furthermore, death rates among the elderly poor are 50 percent higher than those among other Medicare beneficiaries.

The approximately 3.1 million elderly covered by Medicaid can be divided into three groups. The first is those elderly who have incomes low enough to qualify for cash assistance; in other words, the categorically needy. Fifty-four percent of elderly Medicaid beneficiaries (1.7 million) are categorically needy.

The second and third groups are composed of persons who do not receive cash welfare assistance. The second group, the optional categorically needy, comprises about 23 percent of elderly beneficiaries, or about 728,000 people. The third group is the medically needy, which accounts for another 23 percent, or approximately 732,000 people. These two groups include many persons using nursing home care. Many of these beneficiaries were not poor when they entered a nursing home; however, the high costs of nursing home case (in excess of $24,000 per year) result in many middle income elderly "spending down" their resources to Medicaid eligibility levels.

These different groups accounted for widely varying proportions of Medicaid spending for the elderly, largely as a result of their varying utilization of nursing home care, an especially costly service. The categorically needy account for 25 percent of Medicaid expenditures for the elderly; the optional categorically needy, 33 percent; and the medically needy, 42 percent.

In 1986, nursing home costs accounted for two-thirds of payments for elderly Medicaid beneficiaries. Seventy percent of the optional categorically needy and the medically needy elderly used nursing home services, accounting for 58 percent of all Medicaid payments for elderly beneficiaries.[38] Nursing home payments were seven times more for aged beneficiaries than they were for nonaged beneficiaries. Although this results in part because the elderly need and use more nursing home services than the nonelderly, it also reflects the fact that nearly all elderly Medicaid beneficiaries have Medicare as their primary payer of acute health care services. However, because Medicare provides extremely limited coverage of nursing home care, and there is virtually no private insurance available, Medicaid has become the primary source of public funds for nursing home care.

In contrast, expenditures for home care under Medicaid represent a small and static percentage of total program outlays. In 1988, Federal Medicaid expenditures for home health care were $1.5 billion, accounting for 2.7 percent of total Medicaid spending.[39] For a variety of reasons, very few States have made extensive use of this benefit. The benefit itself is very limited, in that only medical services covered. Futhermore, because services must be made available to all Medicaid beneficiaries, States have not been permitted to target services to specific populations, such as the elderly. Many States have taken up the slack and have funded home care out-of-State funds, or have established programs under the Section 2176 waivers, which are discussed below.

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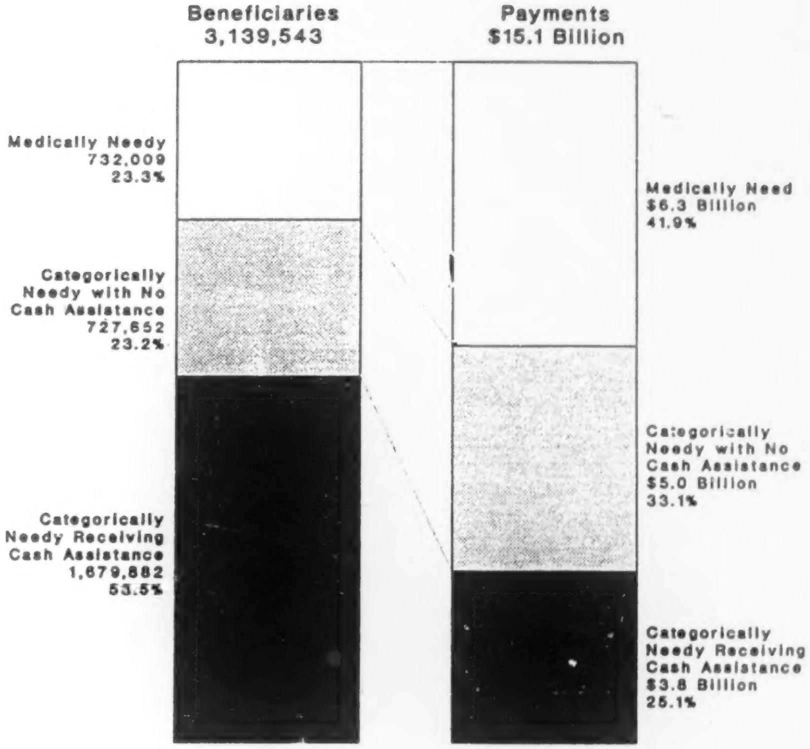
[38] Subcommittee on Health and the Environment, Committee on Energy and Commerce. *Medicaid Source Book: Background Data and Analysis,* Washington, D.C. Committee Print 100–AA.

[39] Office of National Cost Estimates, "National Health Expenditures, 1988." *Health Care Financing Review,* Summer 1990. p. 38.

Aged Beneficiaries and Payments for Aged Beneficiaries By Eligibility Status, FY 1986



Source: HCFA-2082 forms. Figure prepared by Congressional Research Service, Education and Public Welfare Division.

(B) QUALIFIED MEDICARE BENEFICIARY PROGRAM

The Qualified Medicare Beneficiary Program (QMB), which was originally part of the MCAA, requires States to "buy-in" the Medicare premiums, copayments, and deductibles for low-income Medicare beneficiaries with incomes below the Federal poverty level and assets below twice the SSI level ($4,000 in liquid assets). This provision was to be phased-in over 3 years, beginning in 1989 for those beneficiaries with incomes at or below 85 percent of poverty, and increasing in 5 percent increments up to 100 percent of poverty by 1992.

Because of a provision included in the OBRA 1990, the implementation of the QMB program was accelerated by 1 year; in other words, up to 100 percent of poverty by January 1, 1991. OBRA 1990 also requires States to buy-in the Part B premiums (but not other copayments and deductibles) for Medicare beneficiaries with assets below twice the SSI level and incomes below 110 percent of poverty beginning in January 1, 1993, going up to 120 percent of poverty by January 1, 1995.

There have been some problems with the QMB program; most notably, participation rates have been lower than anticipated. Although HHS does not have any national data, participation is estimated to be between 20 and 30 percent. This is largely because many low-income elderly do not know about the program. While some States have been more aggressive than others in informing the public about the QMB program, many aging advocates believe that a more active role on the part of HHS in promoting the QMB program could serve to increase participation rates across the country.

(C) SPOUSAL IMPOVERISHMENT

A particularly important concern over the past few years has been the issue of Medicaid spend-down for nursing home care. To become eligible for Medicaid coverage, persons must either be poor or spend-down their income to the level set by their State Medicaid program. While there is a great deal of variability among States' Medicaid programs and income eligibility levels, nursing home residents—and often their spouses—frequently face impoverishment before they become eligible for Medicaid coverage. According to HHS, about one-half of the persons receiving Medicaid coverage for their nursing home care became eligible after they entered the nursing home.

A recent study on the effects of nursing home use on Medicaid eligibility status found that the likelihood of being Medicaid eligible was 31 percent if a person spent time in a nursing home, as opposed to 7 percent for those who had not.[40] Medicaid eligibility is also closely related to the length of stay in a nursing home. Although temporary or short stays in a nursing home do not increase one's risk of spending down to Medicaid eligibility, 41 percent of those persons studied who had long-term stays (i.e., at least 2 years) spent down to Medicaid eligibility.

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[40] Liu, Korbin, and Kenneth G. Manton. "The Effect of Nursing Home Use on Medicaid Eligibility." *The Gerontologist,* Vol. 29, Nov. 1, 1989, p. 63.

A provision in the MCCA addresses this issue of Medicaid spend-down. Although most of MCCA was repealed in November 1989, the so-called "spousal impoverishment" provisions were retained. Effective September 30, 1989, these provisions are intended to protect some of the income and assets of the spouse who remains at home when the institutionalized spouse is in the process of spending down to become Medicaid eligible.

Generally, when determining Medicaid eligibility, income (such as Social Security checks, pensions, and interest from investments) is attributed to the person whose name is on the instrument conveying the funds. In the case of Social Security, the amount attributed to each spouse is the individual's share of the couple's benefit. Therefore, if the couple's pension check is made out to the husband, all of that income would be considered his for the purpose of determining Medicaid eligibility. The attribution of resources such as certificates of deposit and savings accounts is done similarly. Because the current generation of women whose husbands are at risk of needing nursing home care typically did not work outside the home, they likely have very little income or assets other than those in their husband's name.

Prior to the passage of MCCA, once an institutionalized spouse was determined Medicaid-eligible, some of his monthly income was reserved for the use of his spouse. When combined with the community spouse's income (if one existed) it allowed a maintenance needs level, which could not exceed the highest of the SSI, State supplementation, or "medically needy" standards in the State. According to a survey taken by the American Association of Retired Persons in March 1987, maintenance needs levels varied widely from State to State—from a high of $632 in Alaska to zero in Oklahoma. Thus, in a State with a maintenance needs level of $350, if the community spouse's monthly income was equal to $150, the contribution from the institutionalized spouse would have been $200.

Under MCCA, States must allow the community-based spouse to keep at least $856 per month in income in 1990, or 122 percent of the Federal poverty level. This allowance will increase to 133 percent on July 1, 1991, and 150 percent on July 1, 1992. However, the maximum allowance will not exceed $1,500 per month. This provision also provides for a one-time determination of liquid assets, with half attributable to each spouse. The institutionalized person may transfer an amount equal to one-half, or $12,516 (in 1990), whichever is higher, to the spouse, up to $62,580 (the amount of protected assets increases each July 1, based on the increase in the Consumer Price Index). For example, if the couple has assets worth $20,000, the institutionalized person may transfer $12,516 to the spouse. If they have assets worth $130,000 the institutionalized person may transfer $62,580 to the spouse, keeping the remainder for him/herself. In other words, if the spouse's share of assets exceeds $62,580, the excess is attributed to the institutionalized person. States have the option to increase the minimum level of protected income to any amount above $12,516, up to $62,580, which approximately 21 States have done.

(D) PERSONAL NEEDS ALLOWANCE FOR MEDICAID NURSING HOME RESIDENTS

Nearly 800,000 Medicaid nursing home residents depend on their personal needs allowance (PNA) each month to cover a wide range of expenses not paid for by Medicaid. The current amount of the PNA is $30 per month—or $1 per day. With the passage of OBRA 1987, the PNA was increased from $25 to $30 per month, effective July 1, 1988. Prior to this, the PNA had not been increased—or even adjusted for inflation—since Congress first authorized payment in 1972. As a result, the $25 PNA was worth less than $10 in 1972 dollars. And while the $5 monthly increase in the PNA is an improvement, there is no provision for a cost-of-living adjustment (COLA) in the PNA. Thus, all recipients of Social Security and SSI benefits have received COLA's to their benefits since 1974, except the frailest and most vulnerable—Medicaid nursing home residents.

For impoverished nursing home residents, the PNA represents the extent of their ability to purchase basic necessities like toothpaste and shampoo, eye glasses, clothing, laundry, newspapers, and phone calls. In addition to personal needs, many nursing home residents have substantial medical needs that are not covered by State Medicaid programs. Although the PNA is not intended to cover medical items, these residents may have to save their PNA's over many months to pay for these costs, such as hearing aids and dentures.

If a nursing home resident enters a hospital, he must pay a daily fee to the nursing facility to reserve his bed there. Even though a resident who cannot pay this fee is likely to lose his place in the nursing home, 40 percent of State Medicaid plans will not cover the cost nor guarantee the nursing home resident a bed to come back to. While the $30 monthly PNA represents an improvement over the $25 monthly PNA, many advocates of the Nation's nursing home residents believe it still is not adequate to meet the needs of most residents.

(E) MEDICAID SECTION 2176 WAIVERS PROGRAM

Prior to 1981, Federal regulations limited Medicaid home care services to the traditional acute care model. To counter the institutional bias of Federal long-term care spending, Congress in 1981 enacted new authority to waive certain Medicaid requirements to allow States to broaden coverage for a range of community-based services and to receive Federal reimbursement for these services. Specifically, Section 2176 of the OBRA 1981, authorized the Secretary of HHS to approve Section 2176 waivers for home- and community-based services for a targeted group of individuals who, without such services, would require the level of care provided in a nursing facility or intermediate care facility, or who are already in such a facility and need asssistance returning to the community. The target population may include the aged, the disabled, the mentally retarded, the chronically mentally ill, persons with AIDS, or any other population defined by the State as likely to need extended institutional care. Community-based services under the waiver include case management, homemaker/home health aide services, personal care services, adult day care services, habilitation services, respite care, and other community-based services. As of November 1990, 47 States had approved waiver programs; of that amount, 38 States currently have waivers for the elderly. In 1987, waivers for the elderly and disabled served 60,000 people.

HCFA has expressed concern that the home and community-based waiver program may actually increase Federal expenditures for long-term care. While home- and community-based care may be less costly on an individual recipient basis, aggregate Medicaid costs may increase if the program results in the provision of a new range of services to persons who would not otherwise use nursing homes or other institutional care funded by Medicaid. Previous research and demonstration efforts in home- and community-based care suggest that achieving program savings depends on how effectively waiver services are targeted. HCFA has argued that targeting the services to the population most at risk of entering an institution is quite difficult, if not impossible.

The Section 2176 waivers have proven to be very popular with States, and Congress has taken action to ensure their continued availability. OBRA 1987 included provisions aimed at expanding the program. It created a new waiver authority (Section 1915(d) waivers) under which States can provide home- and community-based services for the elderly alone. Under the 1915(d) waiver program, the requirements that the program be statewide and comparable for all eligibility groups may be waived. In addition, income and resource rules applicable to persons residing in the community may be waived. Expenditures for skilled nursing facility services, intermediate care facility services, and home- and community-based services for individuals age 65 and older may not exceed a projected amount, which is determined by comparing the amount spent in the base year for such services, increased by factors that take into account increases in the cost of goods and services, the over-age 65 population, and the level of services provided. As of 1990, only Oregon has received authority from HCFA to provide services under the 1915(d) waiver.

C. LEGISLATION/INITIATIVES IN THE 101ST CONGRESS

1. Nursing Home Care

The demand for nursing home services is expected to escalate over the next several years because of the growing population of older Americans. The age 65 and older group is expected to increase from the present level of 25 million to 36 million by the year 2000. More notably, the age 85 and over population (those most at risk of needing institutional care) is expected to increase from 2.5 million at the present time to 5 million in the year 2000—an increase of 100 percent.

As interest in providing comprehensive long-term care services to our Nation's elderly continues to grow, it is likely that issues surrounding nursing home care will become the focus of increased congressional and public attention. Following is a discussion of the pertinent nursing home issues of the past few years, including:

nursing home quality of care and the OBRA 1987; and the long-term care ombudsman program under the Older Americans Act.

(A) NURSING HOME QUALITY OF CARE AND OBRA 1987

Quality of care in nursing homes has been an item of great concern to the elderly and their advocates for a number of years. During the 1980's, several investigations and studies, including a 2-year investigation (completed in 1986) by the Senate Special Committee on Aging,[41] a report by the GAO,[42] and a report by the Institute of Medicine,[43] found that thousands of frail elderly citizens live in nursing homes that fail to provide care adequate to meet even their most basic health and safety needs. Legislation was passed in 1987 to implement many of the recommendations of the various studies and aging advocacy organizations. OBRA 1987 contains extensive nursing home quality care provisions. This legislation will be outlined in greater detail below, following a discussion of the findings that led to its passage.

In response to congressional concern about controversial nursing home regulations proposed by HCFA in 1982 to essentially "deregulate" the nursing home industry, HCFA commissioned a study in 1983 from the Institute of Medicine (IOM) of the National Academy of Sciences. According to the contract, this study was to "serve as a basis for adjusting Federal (and State) policies and regulations governing the certification of nursing homes so as to make those policies and regulations as appropriate and effective as possible." The study was begun in October 1983 and released in 1986. It concluded that the quality of care and quality of life in many nursing homes are unsatisfactory, and that a stronger Federal role is essential to improve the quality of care. The study made a number of recommendations to strengthen and improve the current Federal regulations that were incorporated into the 1987 law. These recommendations included the elimination of the distinction between SNFs and ICFs, the use of intermediate sanctions to enforce compliance with regulations, and the strengthening of residents' rights.

The Special Committee on Aging's investigation found many of the same problems. For example, the Aging Committee disclosed that nursing home inspection reports from HCFA revealed that in 1984, more than one-third (3,036) of the Nation's 8,852 certified SNFs failed to comply with the most essential health, safety, and quality standards of the Federal Government. About 1,000 (11 percent) of the SNFs violated three or more of these standards. GAO found that 41 percent of SNF's and 34 percent of ICF's nationwide were out of compliance during three consecutive inspections with 1 or more of the 126 skilled or 72 intermediate care facility requirements considered by experts to be most likely to affect patient health and safety. Penalties or sanctions to enforce compliance were found to be severely lacking.

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[41] U.S. Senate, Special Committee on Aging. *Nursing Home Care: The Unfinished Agenda.* S. Prt. 99-160, GPO: Washington, D.C., May 1986.

[42] GAO. *Medicare and Medicaid: Stronger Enforcement of Nursing Home Requirements Needed.* GAO-HRD-87-113, Washington, D.C., May 1987.

[43] Institute of Medicine, National Academy of Sciences. *Improving the Quality of Care in Nursing Homes.* National Academy Press: Washington, D.C., 1986.

In 1987, Senator Mitchell and Representatives Dingell, Waxman, and Stark introduced comprehensive nursing home reform legislation, components of which were included in the OBRA 1987. The OBRA 1987 reforms were the result of a virtually unprecedented consensus of Congress, consumers' and nursing home provider groups, professional associations, and aging advocacy organizations. The provisions were written in great detail, similar to agency regulations, leaving little to interpretation. Many contend that this reflected congressional distrust of HCFA and the Reagan administration on this issue. In October and November 1987, HCFA issued two sets of proposed rules to address nursing home quality concerns in what many believe was an attempt to illustrate that legislation was not needed.

Below are highlights of the OBRA 1987 nursing home reform provisions. Please note that the implementation dates below are from OBRA 1987, and some have been changed by subsequent legislation, which is discussed later in this section.

Definition of a Nursing Facility.—Eliminates the distinction between SNFs and ICFs as of October 1, 1990, and repeals a requirement that States pay less for ICF services than for SNF services; as of October 1, 1990, all nursing homes participating in either Medicare or Medicaid must meet the same requirements for provision of services, the rights of residents, staffing and training, and other administrative matters.

Requirements for Care.—As a condition of participation in Medicare or Medicaid, facilities must, at least once a year, conduct a comprehensive assessment of each patient's ability to perform such everyday activities as bathing, dressing, eating, and walking. Results of such assessments will be used in a written plan of care, describing how a person's medical, psychological, and social needs will be met.

After January 1, 1989, nursing homes are prohibited from admitting residents who are mentally ill or mentally retarded unless they also require the level of care provided in the facility. Preadmission screening must be completed on all prospective residents, whether the costs of care are covered by private or public sources.

Residents' Rights.—Requires that nursing home residents be informed both orally and in writing of their legal rights, including the rights to: choose a personal physician, and be informed in advance about treatment; be free from physical or chemical restraints; have privacy in accommodations, medical treatment, written and telephone communications; confidentiality of personal and clinical records; and have immediate access to a State or long-term care ombudsman.

Staffing Requirements.—As of October 1, 1990, all nursing facilities participating in Medicare or Medicaid must have at least one registered nurse on duty 8 hours per day, 7 days per week, and at least one licensed nurse on duty, 24 hours per day, 7 days per week. These requirements can be waived under certain defined circumstances, with different waivers in place for Medicare SNFs and Medicaid NFs. All nursing facilities with more than 120 beds must employ at least one full-time social worker.

Training for Nurse Aides.—All nurse aides in facilities participating in Medicare or Medicaid must complete an approved training course (75 hours) that includes instruction in basic nursing skills, personal care skills; cognitive, behavioral, and social care; and residents' rights. States must maintain a registry of individuals who have successfully completed such a course, and must also report instances in which the aide has committed acts of resident neglect or abuse (although the aide will have appeal rights).

Survey and Certification Process.—States are responsible for ensuring compliance with new requirements (except State-owned facilities, which would be monitored by the Federal Government). Each facility is subject of an unannounced "standard survey" on a statewide average of at least one per year, but no less than every 15 months. Facilities found to be delivering substandard care will be subject to an "extended" survey. However, States may impose sanctions based solely on the results of a standard survey.

States also must maintain procedures and staff adequate to investigate complaints of violations of requirements, and to monitor on site, on a regular basis, the compliance of facilities found in violation or suspected of violations.

Enforcement Process, Intermediate Sanctions.—If a State or the Federal Government finds a facility out of compliance and the deficiencies immediately jeopardize the health or safety of the residents, the State or HHS must take immediate action to correct the deficiencies through the appointment of temporary management or terminate the facility's participation in the Medicare or Medicaid program.

If the facility's deficiencies do not immediately jeopardize the health or safety of its residents, the State or HHS may impose one or more intermediate sanctions, terminate the facility's participation or both. Intermediate sanctions include denial of payment for new Medicare or Medicaid admissions, civil penalties for each day of noncompliance, appointment of temporary management for the facility, and emergency authority to close the facility and transfer its residents.

Facilities found out of compliance for 3 consecutive months are automatically subject to denial of payment for new admissions. Facilities remaining out of compliance for three consecutive standard surveys and found to be delivering substandard care are subject to automatic denial of payments and to on-site monitoring by State officials.

(1) Issues in the Implementation of OBRA 1987

The implementation of OBRA 1987 has been fraught with many problems—a lack of guidance from HCFA, concerns among the States and providers about the costs of implementation, and congressional inaction on technical corrections. Many aging advocates and providers contend that one of the biggest stumbling blocks has been HCFA's inability to meet deadlines established by the legislation, and to provide needed guidance on implementation. Because OBRA 1987 requires States to implement the law whether or not they have received guidance from HCFA, HCFA's lack of leadership and guidance on OBRA is particularly troubling. To date, HCFA has only issued two proposed rules implementing OBRA 1987—nurse aide training and Preadmission Screening and Annual Resident Review (PASARR) in March 1990—despite the explicit deadlines that were included in OBRA.

An early example of the frustrations that many have encountered with HCFA is the February 2, 1989, Federal Register "Medicare and Medicaid Requirements for Long-Term Care Facilities: Final Rule with Request for Comments." According to HCFA, these final rules "reflect . . . the comments on the NPRM [the proposed rule published by HCFA in October, 1987, prior to the passage of OBRA 1987] and the requirements of OPRA 1987."

The NPRM had been a point of contention between HCFA and various aging advocacy groups from the beginning, because many believed it was developed in opposition to anticipated OBRA reforms. Final passage of OBRA occurred after the comment period on the NPRM had expired, and critics contended that because OBRA so fundamentally changed HCFA's regulatory mandate, HCFA should have reopened the rulemaking process. HCFA, however, disregarded this criticism, and argued that these final rules, originally effective August 1, 1989, were a "bridge to the new requirements of OBRA 1987 that are effective in 1990." Many aging advocates and providers disagreed, stating that they believed that through the February 2 rule, HCFA was attempting to implement portions of OBRA 1987 that were not effective until October 1990, and without providing an opportunity for public comment. They also argued that many of the regulations simply rewrote the legislative language in OBRA 1987 word for word, without any interpretation. Many believed that the Secretary should have instead focused on issuing the regulations required by OBRA. Ultimately, the implementation date of the February 2 rule was delayed by OBRA 1989 to October 1, 1990.

Many States have encountered problems with OBRA 1987 implementation. The law requires States to submit a plan to HCFA detailing how they will meet the costs of nursing home reform. As of this writing, 12 States do not have approved State plan amendments. In the fall of 1990, California made an unsuccessful attempt to get a waiver from Congress that would have exempted them from complying with OBRA 1987. California officials argued that they are already in substantial compliance with the law, and that nursing facilities would encounter "significant costs" if they had to meet the law's requirements. HCFA rejected their argument, and has withheld $10 million in Federal funding to date. California submitted another plan in December, and it has not yet been approved. In the meantime, consumers have filed a suit that would force California to comply with the law. There is concern that Pennsylvania may be in a similar situation, as State officials believe their current Medicaid reimbursement rates are already sufficient to cover the costs of OBRA implementation. HCFA disagrees, and may take action against the State; Pennsylvania has threatened to file a suit against HCFA.

Until the passage of OBRA 1990, there was little congressional action taken to make technical corrections to OBRA 1987, creating problems for states, providers, and advocates alike. They looked to Congress to make corrections to the existing law, which would help with the implementation, particularly in the absence of guidance from HCFA. In the 1989 budget reconciliation process, a number of OBRA 1987 technical corrections were included in both the House Energy and Commerce and Senate Finance Committee-passed versions of the bill. However, because of the invocation of a rule allowing only those provisions that saved money to be included, many of these provisions were stripped out when the bill was taken up by the full Congress. A number of these provisions were later included in OBRA 1990. Below is a discussion of some of these provisions and other OBRA 1987 related concerns.

Preadmission Screening and Annual Resident Review.—OBRA 1987 requires preadmission screening of mentally ill and mentally retarded nursing home applicants to determine if they need the care that a nursing home provides and, if so, whether they need active treatment. It also requires an annual review of mentally retarded or mentally ill residents to ensure that their continued placement in a nursing home is appropriate. Those suffering from Alzheimer's disease are excepted from this process, otherwise known as PASARR. OBRA 1987 requires that prospective applicants be screened beginning January 1, 1989, regardless of whether the Secretary had promulgated regulations; by April 1, 1990, all such residents who have lived in a nursing home for less than 30 months must be placed elsewhere. Nursing homes that do not comply are subject to a cutoff of all Medicare and Medicaid funds.

This provision was intended to ensure that the mentally ill and mentally retarded get the specialized treatment that they need. It was the hope of those developing the legislation to foster the growth of community-based centers such as groups homes and halfway houses that many States have been slow to encourage. Unfortunately, it is causing a great deal of confusion among State regulatory agencies, as well as among industry and consumer groups for a variety of reasons. While there is agreement that nursing homes are not the most appropriate placement for the mentally disabled, Medicaid has always paid for their care there. Medicaid traditionally does not cover care in other, more suitable settings, such as group homes and halfway houses. The problem is often a result of a lack of funding for this type of care at the State and local levels. However, even if sufficient funding can be found, there are fears that States will not be able to provide services for all those who will need assistance in the alloted timeframe.

Another significant problem is the absence of any substantive guidance from HCFA on the PASARR process. OBRA 1987 required HCFA to develop the PASARR criteria by October 1988. These criteria would provide, among other things, a definition of mental illness and mental retardation. In March 1990, HCFA published proposed rules on PASARR; to date, no final rules have been issued. Issuance will be even further delayed because some provisions in OBRA 1990 require substantial revision of portions of the rule.

OBRA 1990 provisions relating to PASARR include:

—HCFA cannot take enforcement actions against States that make a good faith effort to comply with PASARR before the effective date of the May 1989 HCFA guidelines;

—the definition of mental illness is changed from a "primary or secondary diagnosis of mental disorder described in DSM–III" to "serious mental illness to be defined by HHS in consultation with the National Institute of Mental Health;"

—replaces references to "active treatment" with "specialized services;" and

—States must report to HHS the number and disposition of residents who were discharged from nursing homes because of PASARR.

Nurse Aide Training.—The IOM report found that over 70 percent of the nursing personnel in long-term care facilities are nurse aides, and that as much as 90 percent of resident care is delivered by them.[44] For this reason, the IoM recommended that the Federal Government mandate the training of nurse aides prior to their employment. As a result, OBRA 1987 established new requirements for nurse aide training. The law states that for those nurse aides hired prior to July 1, 1989, nursing homes participating in Medicaid and/or Medicare must provide a competency evaluation program and the preparation necessary for the aide to complete this program by January 1, 1990. For newly hired nurse aides, the law requires that they complete both a training program and a competency evaluation. The training program must include a minimum of 75 hours of initial training. Training and evaluation programs may include those offered by or in nursing homes. OBRA 1987 also requires that Medicare and Medicaid recognize the costs of nurse aide training incurred by facilities. The Secretary was required to establish requirements for approval of these programs by September 1, 1988. To date HCFA has issued only proposed rules in March 1990.

Among the nurse aide training provisions included in OBRA 1989 was a delay from January 1, 1990 to October 1, 1990, the date by which aides must complete training and/or competency evaluation programs and be determined qualified to provide care. It also included provisions to provide for the "grandmothering" of already-employed nurse aides. Those nurse aides who have received 60 hours of initial training and at least 15 hours of supervised practical nurse aide training or in-service education as of July 1, 1989, shall be considered to have completed a training and competency evaluation program. Those nurse aides who have completed a training course of at least 100 hours and have been found competent before July 1, 1989, shall be considered to have completed a training and competency evaluation program as well. Finally, States are authorized to waive the competency evaluation (but not the training) requirements with respect to persons who can demonstrate that he or she has served as a nurse aide at one or more facilities of the same employer in the State for at least 24 consecutive months before the date of enactment.

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[44] *Improving the Quality of Care in Nursing Homes*, p. 89, 90.

There were a number of nurse aide training provisions in OBRA 1990 as well. These include:

- —HCFA cannot take enforcement action against States that failed to meet program requirements before the effective date of May 1989 HCFA guidelines if the State made a good faith effort to comply;
- —temporary or per diem aides employed after January 1, 1991, must meet the same training and competency requirements as other nurse aides;
- —States must reimburse aides' training costs (on a pro rata basis) if they enter into an employment agreement with a nursing facility within 12 months of completing a training and competency evaluation program;
- —a facility is not permitted to conduct nurse aide training if, within the previous 2 years it: (a) has operated under a waiver of nurse staffing requirements in excess of 48 hours per week; (b) has been subject to an extended (or partially extended) survey; or (c) has been subject to certain sanctions, including a civil monetary penalty of not less than $5,000, denial of payment, appointment of temporary management, closure, or transfer of residents.

(2) Nurse Staffing Waivers

The IOM report noted that one of the main factors affecting quality of care and quality of life in nursing homes is the number and quality of nursing staff. Greater numbers of nursing staff have been associated with improved resident outcomes. One of the primary differences between ICFs and SNFs was their nurse staffing requirements. Medicare (and Medicaid) SNFs must have licensed nurses on duty 24 hours per day, including the services of a registered nurse at least during the day shift, 7 days per week. Medicaid ICFs required only that a licensed nurse be on duty on the day shift 7 days per week. A licensed nurse is defined in both cases as a registered nurse, a licensed practical nurse or a vocational nurse.

IOM also looked at the differences between SNFs and ICFs with regard to the needs of residents that they served, and found that the distinctions between the two do not necessarily reflect differences in the residents that they care for. Accordingly, IOM recommended that the distinction between the two types of facilities be eliminated and that participating facilities be subject to the same quality assurance criteria and procedures, including the SNF minimum staffing requirements. OBRA 1987 eliminates the distinction, and creates a new category referred to as a Medicaid nursing facility (NF). As of October 1, 1990, all nursing facilities must meet a single set of requirements for participation in Medicaid. These are almost identical to Medicare's requirements.

For nurse staffing, OBRA 1987 requires that NFs meet Medicare's requirements. However, it provides for a broader waiver authority for NFs than for SNFs. NFs are permitted to waive either the registered nurse and the licensed nurse requirements; SNFs can waive only registered nurse requirements. Waivers will be granted by the States in strictly defined circumstances, and HCFA is in the process of drafting regulations implementing these requirements. Because registered nurses are in short supply nationwide, health care providers often must pay higher salaries to recruit and retain nursing personnel. These higher salary costs, as well as OBRA's mandate for increased nurse staffing, will likely lead to an increase in States' Medicaid costs. For this reason, there is some concern that States will have an incentive to grant waivers. The implementation of this provision of OBRA 1987 will likely be carefully monitored by nursing home consumer groups and State regulatory agencies.

OBRA 1990 contains a provision that will affect nurse staffing waivers. In the February 2, 1989 final rule, HCFA had interpreted the nurse staffing waiver requirements to mean that NFs could waiver either the LPN or RN requirement in its entirety, but not both. The OBRA 1990 provision would allow States to grant waivers of either or both requirements to the extent the NF cannot meet them. For example, if a facility can find an RN for 40 hours during the week but not for the 16 hours over the weekend, the facility would only get a waiver for the 16 hours. However, if a facility can demonstrate that it cannot find any nursing staff for any of its shifts, it can get a waiver for both requirements. Residents, ombudsmen, and protection and advocacy systems must be notified when waivers are granted. The Secretary of HHS is also required to conduct a study and report to Congress on the appropriateness of establishing minimum caregiver-to-resident ratios and minimum supervisor-to-caregiver ratios for SNFs and NFs, and to include recommendations for appropriate minimum ratios.

(3) Other OBRA 1987-Related Issues

There were several other provisions in OBRA 1990 making technical corrections to OBRA 1987. Among them were:

Enforcement.—HCFA cannot take compliance action against States that demonstrate a good faith effort to establish alternative sanctions required by OBRA 1987 prior to the date on which the Secretary of HHS issues guidelines regarding the establishment of remedies for facility noncompliance.

Administrator Licensure.—When HHS issues standards for nursing home administrators, the pre-OBRA 1987 law requiring States to license nursing home administrators and set criteria for State licensing boards will be repealed.

Maintenance of Standards for Personnel.—The Secretary must establish requirements for social workers, activities professionals, and dieticians employed in a nursing facility that are at least as stringent as those requirements in place prior to the enactment of OBRA 1987.

Resident Assessment.—The period for completing the initial assessment is expanded from 4 to 14 days.

PPS for SNFs.—The Secretary is required to develop a proposal to modify the Prospective Payment System for SNFs.

(B) LONG-TERM CARE OMBUDSMAN PROGRAM

The long-term care ombudsman program began as a demonstration project in the early 1970's as a part of the Federal response to serious quality-of-care concerns in the Nation's nursing homes.

These demonstration ombudsman programs were charged with the responsibility to resolve the complaints made by or on behalf of nursing home residents, document problems in nursing homes, and test the effectiveness of the use of volunteers in responding to complaints. As a result of the success of the early programs, Congress incorporated the ombudsman program into the 1978 amendments to the OAA.

Under the OAA, each State is required to establish and operate a long-term care ombudsman program. These programs, under the direction of a full-time State ombudsman, have responsibilities built upon those outlined above. The programs are to: (1) Investigate and resolve complaints made by or on behalf of residents of long-term care facilities, (2) monitor the development and implementation of Federal, State, and local laws, regulations, and policies with respect to long-term care facilities, (3) provide information as appropriate to public agencies regarding the problems of residents of long-term care facilities, and (4) provide for training staff and volunteers and promote the development of citizen organizations to participate in the ombudsman program. The 1981 amendments to the OAA added the requirement that ombudsmen serve residents of board and care homes.

The primary role of long-term care ombudsmen is that of consumer advocate. However, they are not limited to responding to complaints about the quality of care. Problems with public entitlements, guardianships, or any number of issues that a nursing home resident may encounter are within the jurisdiction of the ombudsman. A major objective of the program is to establish a regular presence in long-term care facilities, so that ombudsmen can become well-acquainted with the residents, the employees, and the workings of the facility. This presence is important because it helps the ombudsmen establish credibility and trust. Further, because about one-half of nursing home residents have no family, many may have only ombudsmen to speak on their behalf.

In FY 1989, there were about 600 local ombudsman programs throughout the Nation. According to the AoA, which is the Federal agency responsible for the OAA and the ombudsman program, the number of complaints handled by programs across the country more than tripled from 1982 to 1989, rising from 41,000 in 1982 to 135,000 in 1989. Of the 135,000 complaints received in 1989, AoA reports that about 74 percent were fully or partially resolved.

Funding devoted to the ombudsman program has grown in recent years. In fiscal year 1982, States reported that they spent a total of $10.4 million on ombudsman activities, an amount which grew to over $25 million in fiscal year 1989. Staffing, both paid and volunteer, more than doubled from fiscal year 1982 to fiscal year 1988, from 4,171 to 10,381.

Despite the program's growth and effectiveness, Federal support, in terms of funding and statutory requirements has been inadequate. The IoM's report on the quality of care in nursing homes noted that the ombudsman programs varied widely in their effectiveness, and stated the need to make improvements to the program in the future.

To address these concerns, the OAA amendments of 1987 (P.L. 100–175) contained several provisions to strengthen and improve the long-term care ombudsman program. Among the provisions is a requirement that States provide access to facilities and to records, and immunity to ombudsmen for good faith performance of duties. Further, States must provide adequate legal counsel and representation to ombudsmen if it is needed. Each State must also ensure that any willful interference with the official duties of ombudsmen is unlawful, and that retaliation or reprisals against facility residents and others who complain or cooperate with ombudsmen are unlawful.

The law also requires States to provide for the training of all personnel, including volunteers, in the ombudsman program in Federal, State, and local laws with respect to long-term care facilities in the State, in investigative techniques, and in any other areas the State deems appropriate.

The 1987 legislation also required improved AoA reporting on the ombudsman program. It required that AoA submit to Congress, on an annual basis, information on complaints and conditions in long-term care facilities and recommendations on ways to improve conditions, among other things. In addition, the Commissioner of AoA was required to submit a report to Congress by December 31, 1989, on the findings and recommendations of a study on the impact of the long-term care ombudsman program on the care of residents of board and care facilities, and other adult care homes, as well as the effectiveness of recruiting, supervising, and retaining volunteers. The study found that State long-term care ombudsman programs appear to have a significant role in monitoring board and care legislation and regulation, as well as in coordinating with other agencies. The 48 States participating in the study were evenly divided as to whether their impact on board and care homes was significant, moderate, or slight.[45] The study on the use of volunteers in ombudsman programs found that of the 46 States responding, 26 categorized themselves as using mostly volunteer staff, and 20 used primarily paid staff. However, 80 percent of the paid programs expressed interest in developing or expanding their volunteer capacity.[46]

Congress for the first time established a separate authorization of funds for the ombudsman program in the 1987 OAA amendments, with an authorization of $20 million in fiscal year 1988, and such funds as may be necessary in fiscal years 1989-91. In 1990, Congress appropriated $975,000. In 1991, Congress appropriated $5.367 million for ombudsman and elder abuse prevention services. In the conference report on the Labor, HHS, and related agencies appropriations bill, the conferees indicated that portions of elder abuse funds be made available to State long-term care ombudsman programs.

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[45] "A Study of the Involvement of State Long-Term Care Ombudsman Programs in Board and Care Issues." Prepared for the Administration on Aging by the National Center for State Long-Term Care Ombudsman Resources at The National Association of State Units on Aging, Washington, D.C. December 1989.

[46] "A Study of the Use of Volunteers by State Long-Term Care Ombudsman Programs: The Effectiveness of Recruitment, Supervision, and Retention." Prepared for the Administration on Aging by the National Center for State Long Term Care Ombudsman Resources of The National Association of State Units on Aging, Washington, D.C.

2. MEDICAID'S PRUDENT PHARMACEUTICAL PURCHASING PROGRAM

Aging Committee Chairman Pryor continued to make prescription drugs a focus of his legislative priorities in 1990. His objective was to reduce the cost of prescription drugs for the Medicaid program by seeking enactment of a program that would require prescription drug manufacturers to provide better prices on their products. The Chairman's initiative was successful. Included in OBRA 1990 were prudent pharmaceutical purchasing provisions for the Medicaid program that were expected to save $3.4 billion in tax dollars over 5 years—$1.9 billion for the Federal Government and $1.5 billion for the States. Medicaid is the $50 billion Federal-State health insurance program for the poor. These savings will be achieved by significantly reducing the price that the $5 billion national Medicaid drug program pays for pharmaceuticals. Manufacturers will be required to give the Medicaid program a rebate as a condition of coverage of their drug products.

(A) BACKGROUND

The primary congressional sponsor of legislation designed to provide a better price to the Medicaid program was Chairman Pryor. He wanted the Medicaid program, one of the single largest purchasers of prescription drugs in the country, to have access to the discounts on pharmaceuticals that other smaller purchasers, such as hospitals and HMOs, routinely receive. Some of these discounts are 40 to 70 percent less than what the Medicaid program was paying for drugs.

Pryor's interest in this issue resulted from the Aging Committee hearings that he held in 1989. The purpose of the hearings was to investigate the reasons for the high costs of prescription drugs in the United States, and the impact that these prices were having on publicly funded programs, including Medicaid. During the hearings, it became evident that the Medicaid program was being devastated by skyrocketing prescription drug costs and there was little respite from these increases in sight.

In an effort to hold down drug program costs, State Medicaid programs had tried, unsuccessfully, to negotiate with drug manufacturers to provide better prices and discounts to Medicaid. Because the States were unable to control the costs of prescription drug products, they were implementing cost-containment measures at the expense of good health and access. For example, States were:

—limiting the number of drugs they were covering by developing restrictive drug formularies for Medicaid recipients;

—allowing Medicaid patients to fill a limited number of prescriptions per month, such as three or four;

—implementing cost-sharing mechanisms, such as requiring beneficiaries to pay 50 cents or $1 per prescription; and

—cutting back on pharmacy reimbursement levels, which threatened the availability of pharmaceutical services to Medicaid patients, especially in rural areas.

These measures were poor ways to control drug program costs, because they did not get at the heart of the problem: the manufacturers' price increases. Therefore, Pryor set out in 1990 to require the drug manufacturers to participate in cost containment and to offer a fair deal to the Medicaid program. Chairman Pryor expected and received well-financed, well-organized opposition to his initiatives from the pharmaceutical industry.

The industry's major argument against the initiative was that any loss of industry revenue resulting from a Medicaid drug price reduction bill would threaten the viability of research and development and the discovery of breakthrough pharmaceutical products. The industry's own analysts contended, however, that the losses from a Medicaid rebate program would be minimal for the industry, and the impact on research and development would not "only be manageable, but trivial."

(B) MERCK ANNOUNCES EQUAL ACCESS PLAN

The industry's case against giving discounts or rebates to Medicaid and the credibility of the research and development argument was significantly weakened when Merck, Sharp and Dohme (MSD) announced its Equal Access to Medicines Program in April 1990. Merck, which is the Nation's largest and most research-intensive drug manufacturer, voluntarily offered to give State Medicaid programs the "best price" that they offer to any other customer in the marketplace on their single-source pharmaceutical products, with a minimum rebate of 10 percent.

Under the proposal, Merck would rebate to the State Medicaid program the difference between the price that they charge pharmaceutical wholesalers to buy the product (known as the Average Manufacturer's Price, or AMP), and the best price offered in the market for that product. If this value was lower than 10 percent of the AMP, the Medicaid program would receive 10 percent off the AMP. In return for receiving the discounts, States would be required to cover all of Merck's single-source pharmaceutical products on the State's Medicaid formulary. (Single-source prescription products are those that are still on patent which do not face generic competition in the market.)

Many States immediately accepted Merck's offer, and several other drug manufacturers followed suit in endorsing the voluntary Merck plan, including Bristol Myers-Squibb, Burroughs-Wellcome, Miles Laboratories, and Proctor and Gamble. As more and more companies offered various types of rebate or discount plans, the industry's position about giving better prices to Medicaid seem to be in jeopardy.

While many welcomed the various drug company plans, many in the Congress believed that all drug companies—not just a few—should be offering better prices to the Medicaid program. Senator Pryor did not believe that a voluntary approach to manufacturer rebates for Medicaid would work since there was no guarantee that all companies would participate in voluntary program, no assurance that the manufacturers would offer a deal to all States, or that a manufacturer's participation would continue after the threat of Federal legislation abated.

(C) THE PHARMACEUTICAL ACCESS AND PRUDENT PURCHASING ACT OF 1990 (PAPPA)

Pryor introduced his first bill on May 12. The PAPPA was structured to emulate the successful purchasing practices used by organized health care settings—such as hospitals and managed care organizations—to negotiate or bargain with the manufacturers for better prices on drugs.

The bill required States to form their own buying group, join with another State to form a multi-State buying group, or join a Federal prescription drug buying group. These groups would act as drug purchasing agents for the Medicaid program, and would solicit bids from drug manufacturers to have their products included or covered on the State's Medicaid drug formulary.

In order to stimulate competition in the market, a National Pharmacy and Therapeutics Committee, composed of physicians, pharmacists, and clinical pharmacologists, would group similarly acting drugs by therapeutic class. Such a committee is commonly used by hospitals and other medical institutions to make decisions concerning rational drug use in the institution and to develop therapeutic formulary systems. To make its decisions, the Committee would use the most up-to-date medical and scientific evidence to group all like-acting drugs that would be expected to produce the same therapeutic effect, such as anti-ulcer drugs or classes of anti-hypertensive drugs.

The buying groups would then use this information to require bids from the companies to determine which drug would be indicated as the "preferred drug" in each class. The most cost-effective drug in each class would be designated as the preferred drug. Medicaid patients would receive the preferred drug in each therapeutic class unless the physician indicated on the prescription that the patient, because of medical necessity, required a different drug in that class. If the physician did not indicate that a nonpreferred drug was medically necessary, the pharmacist filling the prescription would have to call the physician to determine if he or she could dispense the preferred drug for the Medicaid patient. CBO estimated that the provisions of the bill would save $1.6 billion over 5 years in Federal tax dollars for the Medicaid program.

The bill was strongly supported by advocacy groups for the poor, including Families USA, the Childrens' Defense Fund, and other groups representing the elderly, including AARP, NCSC, and several members of the Leadership Council of Aging Organizations. Pryor also received strong support from organizations of pharmacy practitioners, such as the American Pharmaceutical Association (APhA), the National Association of Retail Druggists (NARD), and the National Association of Boards of Pharmacy (NABP).

Certain provisions of the bill were criticized by the PMA and several minority groups as an attempt to provide "second class medicine" to the Nation's poor. These groups believed that the bill would lead to restrictive drug formularies which would result in Medicaid patients receiving only the cheapest drug product in each drug class. Others believed, however, that the drug industry was more concerned that the bidding system used in the bill would be employed by other third-party prescription plans and HMOs to bargain with the manufacturers over the price of their drugs.

(D) THE OMB PLAN

Despite criticism from the the PMA, Pryor continued to push his legislation and engendered bipartisan support. The bill had 12 cosponsors in the Senate. Pryor's initiative to reduce Medicaid prescription drug costs received an unexpected but very important endorsement from the President's Office of Management and Budget (OMB). When the President sent up revised budget recommendations on June 20, 1990, it included a program of prudent purchasing for pharmaceuticals that was targeted to save $1.6 billion over 5 years in reduced prescription drug costs.

While it differed in some specifics, the plan was very similar to S. 2605 in how it would achieve savings: drug manufacturers would have to bargain with the Medicaid program over the price of their drugs. Unlike Pryor's plan, however, pharmacists would be able to substitute a preferred drug for Medicaid patients without the knowledge of the physician, a practice known as "therapeutic substitution." In Pryor's bill, the preferred drug could only be dispensed to Medicaid patients with the express permission and knowledge of the physician, a practice known as "therapeutic interchange." Several medical groups, such as the AMA, raised ligitmate concerns about the therapeutic substitution provision in the OMB plan, but the agency signaled its willingness to work with Senator Pryor to fashion a plan that insured that the physician had ultimate control of the drug product dispensed to the patient.

After June, PMA began to step-up its criticism of the OMB and the Pryor plan. They tried to label Pryor's plan as a "therapeutic substitution" bill, when in fact, the physician retained sole and final control over the drug product dispensed in S. 2605.

(E) OTHER COMPANIES ANNOUNCE DISCOUNT PLANS

Three other major drug companies offered plans in the summer of 1990 that would voluntarily provide Medicaid programs with reduced prices on their prescription pharmaceuticals:

- —Glaxo, Inc., announced that it would provide Medicaid programs the same price that it offered to managed care plans for its single source products (namely independent practice association model health maintenance organizations). These discounts would be substantially less than the discounts that Glaxo makes available to other purchasers of its products, such as hospitals and Federal Government purchasers.
- —Pfizer offered the Medicaid program the "best price" that it offered to any purchaser, with a 3-year phase-in period. In 1991, one third of the best price would be offered, two thirds in 1992, and the full best price in 1993.
- —Upjohn offered Medicaid $1.35 for each prescription dispensed with an Upjohn product, although this amount did not reflect the drug ingredient cost to fill the prescription.

Sensing the inevitability of Federal legislation, State Medicaid programs wanted to wait and see what a Federal program looked like before making any other long-term commitments with drug manufacturers. Therefore, only a handful of States signed agreements with these three companies other than MSD. In addition, while Pryor welcomed the plans of these companies, he said that they fell far short of what he wanted for the Medicaid program: the company's "best prices" in the market for the product.

As the summer wound down, Pryor decided to introduce another Medicaid drug discount bill that would respond to the various voluntary plans that the drug companies had offered. Unlike his first bill, which required the manufacturers to bid for the Medicaid business in each State, the second bill required the manufacturers to offers discounts or rebates as a condition of coverage of their products by Medicaid.

(F) THE MEDICAID ANTI-DISCRIMINATORY DRUG PRICE AND PATIENT BENEFIT RESTORATION ACT

The second bill introduced by Chairman Pryor, S. 3029, required the drug manufacturers to offer Medicaid the best price for a prescription drug that the manufacturer charged any purchaser in the marketplace. To assure savings over time and to hedge against manufacturer price increases, the best price could increase no faster than the Consumer Price Index (CPI-U) in S. 3029. The CPI-U is a measure of general inflation in the economy. There was a minimum discount of 10 percent off the average manufacturer's price. State Medicaid programs would be required to cover drugs for those companies that gave discounts, but States could still use a prior authorization process to encourage appropriate utilization of high-priced or clinically misused products. CBO estimated that the bill would save $2.5 billion over 5 years in Federal dollars.

Although some contended that the indexing feature in the second bill was tantamount to price controls on pharmaceuticals, the CBO emphasized to congressional staff that long-term savings in the Medicaid prescription drug program were uncertain unless there was some way in the bill to guard against manufacturer price increases. In addition, Pryor contended, no one was limiting the price that the manufacturers could charge their purchasers. They could still set any price, at any time, to any purchaser in any market. What was being limited was the growth rate in expenditures for drugs purchased by the Medicaid program only, a small part of the average manufacturer's business.

In the final days of the debate, even the industry admitted that the final plan would have some form of indexing to control the growth rate in prescription drug expenditures. The industry advocated that the index be tied to the CPI-Medical (CPI-M). However, because the CPI-M has been double the general inflation rate (CPI-U), the Congress was not willing to allow drug prices to inflate higher than CPI-U for Medicaid.

Pryor's second bill was sponsored in the House by Congressmen Ron Wyden and Jim Cooper, both members of the Energy and Commerce Committee, which has jurisdiction over Medicaid. The bill also received the backing of the same advocacy groups that were with Pryor on the first bill—Families USA, Childrens' Defense Fund, AARP, the National Consumers League, and many other organizations. Pharmacy practitioner associations—APhA, NARD, and NABP—strongly supported the second bill as well.

Recognizing the inevitability of Federal legislation, the PMA finally developed its own plan to reduce Medicaid drug costs shortly after the September hearings ended. The plan would give States a 10 percent across-the-board rebate on single-source prescription drug products, and would limit price increases to the CPI–M. In responding to the plan, Chairman Pryor said that it was an anticompetitive approach to a problem that required a competitive solution. He thought it was unfair to ask Medicaid to accept a 10-percent discount when other smaller purchasers were receiving discounts of 40 to 60 percent.

(G) THE HOUSE-SENATE CONFERENCE

In later October, both the House and the Senate passed their separate versions of the Medicaid prudent purchasing legislation as part of each respective chamber's reconciliation bill. It was up to House and Senate conferees, of which Senator Pryor and Congressman Waxman were members, to reconcile the differences between the bills and draft a compromise that was fair to all parties involved.

One of the first issues to be resolved was the targeted savings from Medicaid prudent pharmaceutical purchasing. While the original target for savings was $1.6 billion over 5 years, the House-Senate reconciliation conference agreed to increase that amount to $1.9 billion to pay for some of the Medicaid expansions. The compromise package was included in OBRA 1990, which is described in the next section.

(H) PROVISIONS OF THE NEW LAW

(1) Impact on the Pharmaceutical Industry

Beginning January 1, 1991, pharmaceutical manufacturers are required to give the Medicaid program a specific schedule of rebates as a condition of coverage of their prescription drug products. For manufacturers of single source and innovator multiple source drug products there is a minimum rebate of 12½ percent off the average manufacturer's price (AMP) for 1991 and 1992, with the minimum rebate increasing to 15 percent in 1993 and beyond. (Single source drugs are those that still have patent protection and do not currently face generic competition; innovator multiple source products are products whose patents have expired and now face generic competition in the market.)

Manufacturers will have to give Medicaid, however, the higher of this minimun rebate or the difference between the AMP and the manufactuer's best price for that product, with a limit of 25 percent of the AMP in 1991 and 50 percent of the AMP in 1992. The AMP is the price that manufacturer's charge wholesalers to buy their products.

In the bill, best price includes those prices that manufacturers offer to for-profit or not-for profit hosptials, HMOs, and certain components of the Department of Veterans' Affairs (VA), and are to be determined regardless of manufacturer's packaging, such as unit dose products. The definition of best price excludes VA depot drug prices and single award contracts (such as the contract that the VA currently has with a major supplier of IV solutions) and "nominal" prices offered to charitable groups or organizations.

These exemptions were made for several reasons. Federal Government depot prices reflect the manufacturer's costs of delivering the product in bulk to a provider, without packaging costs. The provider, such as the VA, then assumes the costs of repackaging and shipping to individual outlets. Medicaid is a reimbursement system, not a direct purchaser of drugs, so it seems unfair for Medicaid to have access to prices that are determined based on this mode of distribution. VA Federal supply schedule (FSS) prices are not excluded from consideration. In addition, Congress did not want to threaten the prices that charitable organizations and clinics such as Planned Parenthood pay for drugs, such as the pennies a pack paid for birth control pills, and therefore excluded them from the definition.

An "additional rebate" will recover any increase in the average manufacturer prices over the rate of inflation, as measured by the CPI-U. That is, manufacturer's prices can inflate no faster than the price in the market as of October 1, 1990, indexed forward by the CPI-U. The additional rebate is calculated on a individual drug basis for the first 3 years, and then switches to a system of aggregation in 1994. The Secretary of HHS is able to change the aggregation formula that is specified in the bill if the formula has the effect of decreasing Medicaid's overall savings on prescription drugs.

Drug manufacturers have signficant incentives to participate in the Medicaid rebate program since there will be no Federal matching funds available for the drugs of those manufacturers that have not entered into a rebate agreement. However, manufacturers that have rebate agreements in effect will have all their products covered by the State Medicaid programs. This fact is particularly important for the drug companies since many States do not cover all drug products of all manufacturers for cost and patient care reasons. In addition, there is usually a significant lag time between the marketing of a new drug and coverage by a State Medicaid program. Now, all new drugs will have to be covered immediately by a State Medicaid program for 6 months after FDA approval.

Congress developed different rebate amounts of generic drug products: the rebates will be 10 percent off the AMP in 1991-93, and 11 percent off the AMP thereafter, with no indexing provisions. These rebates are different from the rebates for the single source and innovator multisource products because the generic industry has more competitive prices and generic companies operate on much smaller profit margins than do the brand name companies.

(2) Impact on State Medicaid Programs

A major objective of the legislation was to provide financial relief to the State Medicaid programs that were having trouble making ends meet in their prescription drug program. States will collectively save $1.5 billion on drug costs over the next 5 years as a result of the legislation. The States do, however, incur some additional responsibilities under the legislation relating to coverage of prescription drug products.

One of the major issues discussed during the debate was Medicaid beneficiaries' access to prescription medications. The manufacturers argued that States were unnecessarily and artificially restricting Medicaid patients' access to drugs for cost reasons, especially new products. The States argued that they just could not afford placing new, expensive drugs on their formulary while they already covered drugs that were as good, and less expensive than new alternatives.

The compromise in the legislation requires States to cover single source drugs and innovator multiple source drugs (when a restrictive prescription has been issued) only if the drug's manufacturer has entered into an acceptable rebate agreement with the Secretary. The drugs of those manufacturers not providing an acceptable rebate will not be eligible for Federal matching funds unless the drug has been designated a "1-A" drug by the FDA and the Secretary has approved the State's determination that the drug is "medically necessary" for the State's population. The FDA rates a 1-A drug if it represents a significant therapeutic advance over drugs that are currently being marketed. States must also place on prior authorization those drugs that are not subject to an acceptable rebate agreement. Prior approval requires the practitioner to obtain permission to use the drug from the States before it can be prescribed or dispensed.

To address the industry's concern that Medicaid patients were arbitrarily being denied access to new, breakthrough drug products, the State Medicaid program has to cover new drugs for a period of 6 months after approval, after which time the State may place the drug on prior approval. The law allows the States to place all drugs on prior approval, and there are a limited number of drugs that States, at their option, may exclude from coverage for Medicaid patients, even if subject to a rebate agreement. This list includes drugs to promote fertility or hair growth, smoking cessation products, barbiturates, benzodiazepines, and others. The bottom line for the States is that they will save millions of dollars each year on prescription drug costs, which should allow them to remove some of the restrictions that have had to be implemented to control costs.

(3) Impact on Pharmacy Providers

Senator Pryor made Medicaid pharmacy reimbursement reform a major policy objective of the legislation. He strongly believed that pharmacists had been unfairly targeted by HCFA as the exclusive focus of drug program cost containment efforts in Medicaid; efforts that were unsuccessful because the pharmacist had no control over the cause of the problem—manufacturer prescription drug price increases.

When the final package was crafted, conferees developed a moratorium on reimbursement reductions for 4 years, beginning January 1, 1991. The moratorium will prevent HCFA and the States from focusing drug program cost containment efforts on pharmacists and will give States sufficient time to study whether current pharmacy reimbursement rates are adequate. To make this determination, the Secretary is required to conduct a study within 2 years of each State's Medicaid pharmacy reimbursement rates, including dispensing fees.

The new Medicaid law also contains several provisions that have the potential to significantly improve the prescribing and dispensing of prescription drugs to Medicaid patients. The bill establishes a comprehensive program of drug use review with a prospective component, which consists primarily of pharmacists' counseling patients on drug use, and a retrospective component, which is designed to identify and correct long-term patterns of drug use or abuse.

With respect to the prospective component, the Congress recognized the professional skills and training of pharmacists by adopting language that asks pharmacists to review the appropriateness of drug therapy at the point of dispensing, and counsel Medicaid patients on the use of their medications. Pharmacists are expected to collect and record drug-related information about the patient and check new or refill prescriptions for drug interactions or adverse drug reactions. This type of screening should contribute to reducing the number and severity of drug-related adverse effects which might occur in the elderly Medicaid population.

The provisions related to counseling ask pharmacists to offer to talk to patients about how to take their medications. The patient counseling guidelines in the bill reflect the national standards adopted by the National Association of Boards of Pharmacy this summer. NABP and the major pharmacy practitioner organizations, APhA and NARD, were strong supporters of these provisions, recognizing that the profession needed to send strong signals to Congress about its role in protecting and enhancing the public health.

Pharmacists will be assisted in fulfilling their counseling responsibilities to Medicaid patients as a result of two demonstration projects that are mandated under the law. The first requires the Secretary to complete a multisite demonstration study (by January 1, 1995) of the cost-effectiveness of paying pharmacists for cognitive (clinical) services, including reimbursing a pharmacist for not dispensing a drug when there is potential for a adverse drug effect. In the other study, the Secretary must conduct a 10-State demonstration project of the effectiveness of providing information (through an electronic claims transfer system) about a patient's drug and medical history that will assist pharmacists in fulfilling patient counseling requirements. Information will be captured in a central repository of information so the pharmacist will have a patient's complete medication profile which would assist in detecting adverse reactions and therapeutic duplications.

In the end, the pharmacy profession stands to gain both in economic and professional terms under the new law. Beyond the 4-year moratorium on reimbursement reductions, the demonstration projects should help pharmacists firmly establish their clinical role in the health care system as more than just dispensers of medications.

3. FEDERAL LONG-TERM CARE INITIATIVES

(A) COMPREHENSIVE LONG-TERM CARE LEGISLATION IN THE 101ST CONGRESS

A number of bills were introduced in the 101st Congress to address the issue of comprehensive long-term care. These bills address the issue from a variety of angles and perspectives, with different financing mechanisms and benefits packages, and varying administrative approaches. They are considered essentially "discussion pieces" in that each piece of legislation is the sponsor's ideal approach to providing comprehensive long-term care. Although no formal action was taken on these bills, when Congress and the executive branch of the Federal Government finally hammer out an approach to long-term care, it will likely combine elements of each.

The following are brief synopses of the key initiatives that were introduced in the 101st Congress:

Mediplan Act of 1990 (H.R. 5300, Stark)—Establishes a new Title XVII of the Social Security Act to provide coverage for nursing home and home- and community-based services for certain chronically ill persons. Benefits would be phased-in over 7 years. Beneficiaries would pay for the first 2 months of nursing home care by 1993 and the first 12 months of care by 1995. Beneficiaries would also pay 20 percent of the costs of nursing home and home- and community-based care and it is financed through a 4-percent increase in individual and corporate income taxes. Persons with incomes below 200 percent of the poverty level would be exempt from the tax.

Elder Care Long-Term Assistance Act of 1989 (H.R. 3140, Waxman)—Amends Medicare to provide coverage of nursing facility and home- and community-based services to chronically dependent persons. Payment for home and community services would be dependent upon an individual's degree of impairment and coverage would be limited to a specified number of hours per week. This bill would cover two-thirds of the costs of nursing home care after the first 60 days for 2 years. After that, the beneficiary would be responsible for 10 percent of the costs of care. It would be financed by removing the cap on wages subject to the Medicare and Social Security payroll tax.

Long-Term Home Care Act of 1989 (H.R. 2263, Pepper).—Establishes a long-term home care benefit under Medicare for the elderly and children. All chroncially ill elderly, disabled, and children needing assistance with at least two ADL's would qualify for home care benefits. Payments for services are limited to a certain percentage of institutional care costs, depending on the eligibility category of the individual and degree of impairment. This would be financed by eliminating the cap on income that is subject to the Medicare payroll tax. No beneficiary cost-sharing is required.

Lifecare Long-Term Care Protection Act (S. 2163, Kennedy).—Amends the Public Health Service Act to provide comprehensive coverage for nursing home and home- and community-based care services for functionally impaired persons. Payment for home- and community-based care would be based on severity of dependency in ADLs, cognitive impairment, age, and other factors. There are two parts to this approach—A (mandatory) and B (optional). Part A benefits would provide 6 months of nursing home care and community-based care with modest copayments. Part B would cover longer nursing home stays. Lifecare would cover 65 percent of the costs of nursing home care; the beneficiary (or insurance or Medicaid) would pay for the rest.

(B) FRAIL ELDERLY LEGISLATION

In 1989, Senator Rockefeller and Congressmen Wyden and Waxman introduced long-term care legislation which utilized the Section 2176 waiver approach. This legislation, S. 1942 and H.R. 3933, would permit states to amend their Medicaid programs to extend coverage for noninstitutional care services to low-income, functionally disabled persons over the age of 65. These services would include home health aides, nursing and personal care services, assistance with household chores, respite care, and adult day health services.

Although this legislation would provide similar types of services as under Medicaid's Section 2176 waivers, this approach has several advantages over the waivers. As discussed earlier, waivers have been very difficult for States for a variety of reasons. Under H.R. 3933 and S. 1942, States are given the authority to choose to provide these services as an option under Medicaid, thus eliminating the need for waivers.

A provision in OBRA 1990 authorizes a capped entitlement of $580 million over 5 years for this program. States will be permitted to provide a variety of home and community-based services to persons age 65 and older who are eligible for Medicaid, and who are unable to perform two of three specified ADLs (toileting, transferring, and eating) or who have Alzheimer's disease and meet Alzheimer's disease-specific ADL criteria. Services will be furnished in accordance with a community care plan developed by a case manager. The Secretary of HHS will be required to estalish minimum quality standards for providers of home- and community-based care as well as the settings in which the care will be provided. States are responsible for surveying and certifying the compliance of providers and the settings. States will also have the option to limit eligibility based on reasonable criteria such as age, degree of functional disability, and need for services, and will not be required to provide services on a statewide basis.

(C) BOARD AND CARE HOMES

"Board and care" is a catch-all term used to describe a wide variety of nonmedical residential facilities, including group homes, foster homes, personal care homes, and rest homes. They may provide room, meals, assistance with activities such as bathing, dressing, and the taking of medication. A 1989 GAO report on board and care in six States [47] found that they are typically located in cities, have an average of 23 beds or less, and are privately operated. Residents of board and care homes frequently have physical limitations requiring some oversight, limited incomes (and are typically Supplemental Security Income recipients), and have often lived in mental institutions because of mental disabilities. They are also unlikely to have friends or relatives visit them on a regular basis.

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[47] *Board and Care: Insufficient Assurances That Residents' Needs Are Identified and Met.* GAO/HRD-89-50, Feb. 1989.

Board and care homes present unique quality of care problems. They provide care for poor, often mentally ill, or disabled individuals who frequently have no place else to go. One of the major problems with operating board and care facilities is that the providers, who are often poor themselves, do not receive enough money from their SSI residents to cover the cost of their care. In 1990, individual SSI recipients received $386 per month and couples received $579 per month. In 1990, 33 States provided optional supplemental payments to persons who resided in board and care homes. The supplemental payments are intended to cover room, board, personal care, and supervision of residents. The task of providing adequate care is complicated further by the fact that many of the residents have illnesses or disabilities that demand more care than the board and care operator can afford or is trained to provide.

In 1976, in response to concern about problems in board and care homes, Congress enacted the Keys Amendment to the Social Security Act. It requires States to certify to HHS that all facilities with a large number of residents receiving SSI meet appropriate standards. A 1987 survey of licensed facilities identified about 41,000 licensed homes, with about 563,000 beds serving the elderly, mentally ill, and mentally retarded. Of this amount, about 264,000 beds were identified as serving the elderly only. Data are not available on the number of unlicensed homes, although it is generally acknowledged that a greater number of homes are unlicensed than licensed.

The Keys Amendment does not mandate Federal regulation on licensure of board and care homes. There is only one enforcement sanction available to punish provision violators—the power to reduce the SSI checks of residents of homes not in compliance with State regulations, which acts as a disincentive for States to report deficiencies. Although all States now have health and safety provisions in law, Federal efforts to enforce board and care home standards have been hampered by lack of direct Federal funding of these facilities (SSI benefits are paid directly to board and care home residents or their representative payee, not the facility). This contrasts with nursing homes, where Federal Medicaid and Medicare programs pay the provider of care directly. Consequently, the Federal Government has been able to achieve stronger regulatory requirements for nursing facilities.

Problems exist in licensed and unlicensed homes alike; in other words, licensing does not ensure quality care. Licensing requirements vary widely from State to State, and most inspections focus on the physical plant, with little or no emphasis on the residents and their quality of life. Because States do not aggregate the data gleaned from the inspection reports, the GAO report was limited in its ability to determine that magnitude and type of the violations or the kinds of homes in which the violations frequently occur.

However, GAO did find that homes with predominately low-income residents (i.e., SSI recipients) had about twice as many violations on the average as homes with predominately private-pay residents.

The HHS has played a circumscribed role in overseeing board and care facilities. While the Keys Amendment requires States to establish and enforce board and care standards, it only requires HHS to receive the States' annual certifications concerning compliance. According to GAO, HHS allocates the equivalent of only one-eighth of one person's time to checking that the States have sent in their certifications. Under this policy of very limited follow-up and oversight, a State can report its compliance with Keys even though it may have done little or nothing with respect to monitoring or licensing board and care homes.

In March 1989, the Senate Special Committee on Aging, the House Select Committee on Aging Subcommittee on Health and Long-Term Care, and the Subcommittee on Housing and Consumer Interests held a hearing to examine the problems as well as the attributes of the board and care system, and to explore ways to solve the problems while preserving these facilities' desirable qualities. The hearing found that many board and care homes provide grossly substandard care.

Because they offer independence and autonomy as well as some supervision, board and care homes can provide many elderly persons with an alternative to more costly institutional care. With the implementation of the OBRA 1987 regulations regarding screening and appropriate placement of mentally ill and mentally retarded nursing home patients, the role of board and care homes will likely become even more important. Legislation was introduced the 102nd Congress to address some of the problems facing board and care residents and providers. These bills are H.R. 2219, the National Board and Care Reform Act of 1989, introduced by the late Representative Claude Pepper, and H.R. 3203, the Supplemental Security Income Community Living Amendments of 1989, introduced by Representative Fortney Pete Stark. The aforementioned frail elderly home- and community-based services program that was included in OBRA 1990 may also have an impact on board and care, as it requires the setting where covered services are provided to be surveyed and certified according to Federal guidelines.

(D) THE PEPPER COMMISSION

The U.S. Bipartisan Commission on Comprehensive Health Care was established—and retained—under MCCA. It is also known as the Pepper Commission, after the late Congressman Claude Pepper, who was instrumental in its formation. It was established to study and recommend to Congress ways to finance comprehensive long-term care, comprehensive health care services for the elderly and disabled, and comprehensive health care services for persons of all ages.

The 15 members of this Commission are: Senators Baucus (D-MT), Durenberger (R-MN), Heinz (R-PA), Kennedy (D-MA), Pryor (D-AR), and Rockefeller (D-WV); Representatives Gradison (R-OH), Oakar (D-OH), Stark (D-CA), Stokes (D-OH) who replaces Congressman Pepper, Tauke (R-IA), and Waxman (D-CA); and

Presidential appointees John Cogan, formerly of the Office of Management and Budget, James Davis, former president of the American Medical Association, and James Balag from the health insurance industry. Senator Rockefeller is the chairman of the Commission, a position held by Congressman Pepper until his death in June 1989.

The Pepper Commission, after more than 18 months of hearings, released its final report and recommendations in September 1990. Its recommendations for long-term-care reform use a public-private insurance model for financing expanded long-term-care benefits. The proposal has three components: (1) a federally financed social insurance program covering home- and community-based care for severely disabled persons of all ages; (2) a federally financed social insurance program covering the first 3 months of a nursing home stay; and (3) a means-tested Federal and State financed nursing home program covering stays beyond 3 months that would protect certain levels of income and assets of persons needing care. For both the home- and community-based care program and the first 3 months of a nursing home stay, individuals would be responsible for 20 percent of the costs of care, with the Federal Government subsidizing this cost-sharing requirement for those with incomes below 200 percent of poverty. For nursing home stays of longer than 3 months, persons would be required to apply to the costs of their care nonhousing assets in excess of $30,000 for a single person, and $60,000 for married persons before the program would begin to cover the costs of their care. Individuals would also be required to contribute to the cost of their care income that remains after certain allowances for housing and personal needs. Private long-term-care insurance would fill in the gaps that are not covered by this plan. The estimated cost of this proposal over 1 year is estimated to be $42.8 billion.

The Commission also developed recommendations on universal health insurance. Their proposal has five parts: (1) employers and the Federal Government should provide a minimum level of health care coverage for workers and nonworkers; small employers should be encouraged through tax credits and subsidies to provide health insurance for their employees; (2) Employers, employees, and the Federal Government should share in the responsibility to provide coverage; (3) private insurers and the Federal Government should each play a role in administering health care coverage; private insurance practices that are making it increasingly difficult for small employers to provide care should be ended, and the responsibility for providing public coverage (largely through the Medicaid program) should be shifted from the States to the Federal Government; (4) universal health care coverage should meet minimum standards, including primary and preventive care; and (5) immediate attention needs to be focused on these issues, although implementation must be done thoughtfully and one step at a time.

The Pepper Commission is one of three government groups focusing on comprehensive health care insurance. The Advisory Council on Social Security, formed at the behest of the White House, will issue its recommendations in summer 1991 and a task force appointed by the Secretary of HHS will report in late 1991.

D. PROGNOSIS

Although legislative activity in the 101st Congress with regard to long-term care was limited, it marked another year of incremental progress toward the provision of a broader range of quality long-term care services for the elderly. For example, Senator Rockefeller's Medicaid Community Options bill (S. 1942) was included in OBRA 1990. One of the more noteworthy developments was the repeal of MCCA. Although momentum for repeal of the law gathered for a variety of reasons, a significant factor was the concern of many beneficiaries that MCCA did not provide long-term care.

Fortunately, some provisions of MCCA were salvaged, among them the U.S. Bipartisan Commission on Health, the Qualified Medicare Beneficiary program, and protection against spousal impoverishment, all of which are discussed earlier in the chapter. The recommendations of the Pepper Commission with regard to comprehensive long-term care for the elderly and disabled, and health care coverage for the underinsured and uninsured populations, will likely be the center of debate in the 102d Congress. One of the biggest issues that the Congress must address is the relative roles the public and private sectors will play in the financing of long-term care. This is an issue that shapes nearly every debate on long-term care, and regardless of the recommendations of the Pepper Commission, it will continue to be a contentious and volatile one.

Although there is little consensus on many aspects of long-term care, there is one area in which nearly everyone agrees: the enormous cost of providing comprehensive long-term care to the frail and disabled. In this time of huge Federal deficits, a war in the Persian Gulf with no immediate end in sight, an economic recession, as well as many pressing social needs, such as homelessness, the drug crisis, and the burgeoning numbers of people in this country with no or very limited access to basic health care, finding the necessary funding will continue to be difficult. The Federal Government's interest and commitment to providing long-term care continue to grow, however, as is evidenced by not only the interest in the Pepper Commission, but also the Bush administration's formation of two groups to examine the same problems.

Elsewhere, a number of demonstration projects funded by the Office of Research and Demonstration at HCFA are aimed at testing the effectiveness of community-based and in-home delivery systems for long-term care services. These projects include social health maintenance organizations, which provide for the integration of social and health care services, and respite care for impaired elderly. Similar projects are taking place at the State and local levels, as well as at colleges and universities.

Overseeing the implementation of the OBRA 1990 Medicaid drug purchasing law will be a top priority for the Aging Committee. The Federal Government, the States, and advocates will be working to assure that the Medicaid program gets the savings it deserves and to guard against cost-shifting by the drug industry.

Health care reform will undoubtedly be at the top of most Members' lists in the 102d Congress. Although fundamental reform may be years away, the need for change is so urgent that Congress will be forced to seriously address these issues. Increased emphasis will be placed on exploring alternatives to traditional long-term care. Congressional hearings and legislation designed to foster the development of creative alternatives to institutional care are anticipated, as are ways to reform the current Medicaid system, which is fraught with a myriad of problems.

Chapter 9

HEALTH RESEARCH AND TRAINING

A. BACKGROUND

With the rapid expansion of the Nation's elderly population, the incidence of diseases, disorders, and conditions afflicting the aged also is expected to increase dramatically. The frequency of Alzheimer's disease and related dementias, for example, is projected to double before the end of the century and to quadruple by 2040 if biomedical researchers do not identify the cause and develop effective treatments. A commitment to expand aging research could substantially reduce the escalating costs of long-term care for the older population.

Although scientific and medical research is helping to decrease or, in some cases, eradicate diseases specifically affecting the elderly population, research has not kept up with the growth rate of this population. The Federal Government's investment in health research, estimated at $9.23 billion in fiscal year 1989, is only about 1.7 percent of the total spending on health care in the United States (estimated at $554.8 billion in 1989). Fiscal year 1991 appropriations for the National Institutes of Health (NIH) totaled $8.28 billion, an increase of $700 million, or 9.2 percent, over the 1990 amount.

The National Institute on Aging (NIA) is the largest single recipient of funds for aging research. NIA was given an increase of 35 percent for its fiscal year 1991 appropriations, to $323.8 million. This is by far the largest percent increase for any of the National Institutes of Health. This increase in aging research funding is significant to not only older Americans, but to the American population as a whole. Research in Alzheimer's disease, for example, focuses on treatments and possible preventions for this debilitating disease. Any positive conclusions that come from this research will help to reduce the cost of long-term care that burdens society as a whole. In addition, research into the effects that caring for an Alzheimer's victim have on family and friends could lead to an improved system of respite care, extended leave from the workplace, and overall stress management. Therefore, the benefits derived from an investment in aging research applies to all age groups.

Several other institutes at NIH, as well as the Alcohol, Drug Abuse and Mental Health Administration (ADAMHA), particularly the National Institute of Mental Health (NIMH), are also involved in considerable research of importance to the elderly. The basic priority at NIA is to understand the aging process and to recognize the differences between aging and the diseases and environmental or lifestyle factors that affect older persons. What is being discovered is that many changes previously attributed to "normal aging" are actually the result of various diseases. This is critical because, if a disease can be specified, there is hope for treatment and, eventually, for prevention and cure.

In July, the Senate Special Committee on Aging, in conjunction with NIA, held a staff briefing on "New Research on Aging: Changing Long-Term Care Needs by the 21st Century." The briefing highlighted some of the most promising areas in the field of aging research, including interventions to cure and possibly prevent osteoporosis and frailty. The focus of the briefing was to bridge the gap between the often complex world of biomedical research and the public policy arena.

Currently, it is estimated that 36 percent of all health costs in the United States are spent on the 12 percent of the population that is over age 65. With the projected rapid expansion of the aging population, it is expected that by the year 2000, one-half of each health care dollar will be spent on older Americans.

The health care system in the United States is unable to deal with the current needs of elderly patients suffering from dementia and other diseases. To meet those needs, the Federal Government is expanding the scope of its research on how to meet the more immediate needs of Alzheimer's disease patients and their families.

In the final days of the 101st Congress, the "Home Health Care and Alzheimer's Disease Amendments of 1990" was signed into law (P.L. 101-557). The purpose of this legislation is to combat the major diseases and conditions that impair the independence of older Americans and their families, particularly Alzheimer's disease and related dementias, as well to reach out to Alzheimer's victims and their families with needed support, education and services. This legislation expands the Alzheimer's disease grant program, under which States coordinate the development and operation of services (such as diagnosis, care management, respite care, and education for the patients and their families) with public and private organizations. Two additional provisions in the legislation are significant to age-related research: the creation of the Task Force on Aging Research and the establishment of the Claude D. Pepper Older Americans Independence Centers.

The Task Force on Aging Research will coordinate all federally sponsored research on conditions and diseases leading to dependence among the elderly and identify the most promising areas of research. The task force will be comprised of officials from the Department of Health and Human Services, Veterans' Affairs, and Social Security, as well as Members of Congress. Three members of the general public will also serve on the task force.

The Claude D. Pepper Older Americans Independence Centers will conduct research on promising and innovative approaches and interventions designed to enhance the independence of older Americans and help to ensure their continued productivity. The centers are intended to reduce the need for long-term care.

1. THE NATIONAL INSTITUTES OF HEALTH

The NIH seeks to improve the health of Americans by increasing the understanding of the processes underlying disease, disability and health, and by helping to prevent, detect, diagnose and treat disease. It supports biomedical and behavioral research through grants to research institutions, conducts research in its own laboratories and clinics, and trains young scientific researchers.

With the rapid aging of the U.S. population, one of the most important research goals is to distinguish between aging and disease in older people. Findings from NIH's extensive research increasingly challenge health care providers to seek causes, cures and preventive measures for many ailments affecting the elderly, rather than to dismiss them as being the effects of the natural course of aging. A more complete understanding of normal aging, as well as of disorders and diseases, also facilitates medical research and education, and health policy and planning.

(A) HISTORY OF NIH

NIH traces its beginning as a health research organization of the Federal Government to the establishment in 1887 of the Laboratory of Hygiene, which conducted research on cholera and other infectious diseases in 1887 as part of the Marine Hospital Service at Staten Island, NY. The Marine Hospital Service was a forerunner of the present Public Health Service. In 1930, Congress passed the Ransdell Act, which renamed the Laboratory of Hygiene and created the National Institute of Health. The Ransdell Act also authorized a system of fellowships and the construction of two buildings "for study, investigation, and research into the fundamental problems of the diseases of man."

With the passage of the Social Security Act in 1935, up to $2 million annually was authorized for the "investigation of disease and problems of sanitation," but appropriations ranged from $375,000 in fiscal year 1936 to $707,000 in fiscal year 1940. Congress authorized the creation of the National Cancer Institute in 1937 as a division of the Public Health Service. Congress revised and consolidated the Public Health Service in 1944, giving NIH its postwar legislation basis and establishing permanent, general authority to conduct research.

The National Heart Act, passed in 1948, established the National Heart Institute and changed the name of the National Institute of Health to the National Institutes of Health. Since then, many more institutes have been established and the annual NIH budget has grown from $8 million to almost $7.1 billion.

(B) HEALTH RESEARCH EXTENSION ACTS OF 1983 AND 1985

These bills, which amended the Public Health Service Act relating to the NIH, became a point of confrontation between the administration and the Congress. The Health Research Extension Act of 1983 was passed by Congress and then pocket vetoed by the President in 1984 after Congress adjourned. It was reintroduced in 1985, again passed by Congress and, once again, was vetoed by the President. This time, however, the veto was overridden by a 380-32 vote in the House and 89-7 vote in the Senate.

The administration's objections focused on the creation of a new nursing research center, the imposition of a uniform set of authorities on all research institutions, and additional administrative and program requirements. However, in 1985, the President, in his veto message, acknowledged the need to establish a National Institute of Arthritis.

The new legislation also reauthorized the National Cancer Institute and the National Heart, Lung and Blood Institutes, established a Biomedical Ethics Advisory Board, increased emphasis on the need for humane care of laboratory animals, and provided explicit statutory authority for each of the institutes while retaining the authority of the Secretary of the Department of Health and Human Services to support research and reorganize the institutes.

(C) HEALTH OMNIBUS PROGRAMS EXTENSION ACT OF 1988 (P.L. 100–607)

A number of programs relating to NIH were reauthorized by the Health Omnibus Act. A new Institute was also created under this law, the "National Institute on Deafness and Other Communication Disorders," which is concerned with disorders of hearing and other communications processes, including diseases affecting hearing, balance, voice, speech, language, taste, and smell. It is estimated that 22 million Americans have partial or total loss of hearing and another 2.3 million Americans suffer from communication disorders. About half of these persons are over 65 years of age.

The two largest Institutes, the National Cancer Institute (NCI) and the National Heart, Lung, and Blood Institute (NHLBI), were reauthorized for 3 years. The law also established the "National Center for Biotechnology Information" for the design and development of automated computer systems to be used for research concerning human molecular biology, biochemistry and genetics.

(D) THE INSTITUTES

Much of the NIH research into particular diseases, disorders and conditions is collaborative, with different institutes investigating pathological aspects related to their specialty. At least 11 of the NIH research institutes investigate areas of particular importance to the elderly. They are:

National Institute on Aging
National Cancer Institute
National Heart, Lung, and Blood Institute
National Institute of Dental Research
National Institute of Diabetes and Digestive and Kidney Disease
National Institute of Neurological Disorders and Stroke
National Institute of Allergy and Infectious Diseases
National Eye Institute
National Institute of Arthritis, Musculoskeletal, and Skin Diseases
National Institute on Deafness and Other Communication Disorders
National Center for Nursing Research

(1) National Institute on Aging

The National Institute on Aging (NIA) was established in 1974 in recognition of the many gaps in the scientific knowledge of aging processes. NIA conducts and supports a multidisciplinary program of geriatric research, including research into the biological, social, behavioral, and epidemiological aspects of aging. Through research and health information dissemination, its goal is to prevent, alleviate, and eliminate the physical, psychological, and social problems faced by many older people.

Specific NIA activities include: diagnosing, treating and curing Alzheimer's disease; investigating the basic mechanisms of aging; reducing fractures in frail older people; researching health and functioning in old age; improving long-term care; fostering an increased understanding of aging needs for special populations; and improving career development training opportunities in geriatrics and aging research.

The longest running scientific examination of human aging, the Baltimore Longitudinal Study of Aging (BLSA), is conducted by NIA at the Nathan W. Shock Laboratories, Gerontology Research Center (GRC) in Baltimore, Maryland. More than 1,000 men and women, ranging in age from their twenties to nineties, participate every two years in more than 100 physiological and psychological assessments, which are used to provide a scientific description of aging. According to the BLSA publication, "Older and Wiser", "the objectives of the BLSA are to measure changes in biological and behavioral processes as people age, to relate these measures to one another, and to distinguish universal aging processes from those associated with disease and particular environmental effects." One of the most significant results of the study thus far is that aging does not necessarily result in a general decline of all physical and psychological functions. Rather, many of the so-called age changes appear to be the results of disease, which can often be prevented. The BLSA has entered into its fourth decade, and there are no plans to conclude the research now being conducted.

(2) National Cancer Institute

The National Cancer Institute (NCI) conducts and sponsors basic and clinical research relating to the cause, prevention, detection and treatment of cancer. Of all new cancer cases reported, more than half are elderly patients, and more than 60 percent of all persons who die of cancer each year are older Americans.

The incidence of cancer increases with age. Although aging is not the cause of cancer, the processes are related. More than 80 percent of all cancers occur in persons age 50 and older, and 58 percent occur in people age 65 and over. The rate of cancer survival has increased from 30 percent in 1950 to 50 percent today due to advancements in surgery, radiation and chemotherapy treatment. However, the rate of overall cancer incidence and mortality has been increasing, particularly in those age 55 and older.

In addition to basic and clinical, diagnostic and treatment research, NCI supports prevention and control programs, such as programs to stop smoking.

(3) National Heart, Lung, and Blood Institute

The National Heart, Lung and Blood Institute (NHLBI) focuses on diseases of the heart, blood vessels, blood and lungs, and on the management of blood resources. Three of the most prevalent chronic conditions affecting the elderly—hypertension, heart conditions and arteriosclerosis—are studied by NHLBI. In 1987, more than 1 million deaths were reported from all of the diseases under the purview of the institute, with associated economic costs of nearly $165 billion, including $75.5 billion in direct health care expenditures. Nearly 40 percent of all elderly suffer from hypertension, 25 percent from a chronic heart condition, and 8 percent from arteriosclerosis.

Research efforts focus on cholesterol-lowering drugs; DNA technology and genetic engineering techniques for the treatment of emphysema; basic molecular biology research in cardiovascular, pulmonary, and related hematologic research; and regression of arteriosclerosis.

NHLBI also conducts an extensive professional and public education program on health promotion and disease prevention, particularly as related to blood pressure, blood cholesterol, and coronary heart disease. This has played a significant role in the 58 percent decline in stroke deaths and the 40 percent decline in heart disease over the past 20 years.

(4) National Institute of Dental Research

The National Institute of Dental Research (NIDR) supports and conducts research and training in oral health and disease. Major goals of the Institute include the prevention of tooth loss and the preservation of the oral tissues. Other research areas include birth defects affecting the face, teeth, and bones; oral cancer; infectious diseases; chronic pain; epidemiology; and basic studies of oral tissue development, repair, and regeneration.

In a national study conducted in 1986–87, NIDR found that 42 percent of men and women age 65 and older examined in the survey had lost all of their teeth, compared to only 4 percent of adults between age 18 and 65. Older Americans also face extensive periodontal disease, a major cause of tooth loss. Faced with these findings, the institute has expanded oral health research with the elderly and is collaborating with the National Institute on Aging and the Veterans' Administration in an oral health research, promotion and disease prevention project.

(5) National Institute of Diabetes and Digestive and Kidney Disease

The National Institute of Diabetes and Digestive and Kidney Disease (NIDDK) conducts and supports research and research training in diabetes, endocrinology and metabolic diseases; digestive diseases and nutrition; and kidney, urologic and blood diseases.

Diabetes, one of the Nation's most serious health problems and the largest single cause of renal disease, affects 11 million Americans at an annual cost to society of $20.4 billion. Nearly 10 percent of the elderly are believed to be diabetic.

(6) National Institute of Neurological Disorders and Stroke

The National Institute of Neurological Disorders and Stroke (NINDS) supports and conducts research and research training on the cause, prevention, diagnosis and treatment of hundreds of neurological disorders. This involves basic research to understand the mechanisms of the brain and nervous system and clinical research.

Most of the disorders studied by NINDS result in long-term disabilities and involve the nervous system (including the brain, spinal cord, and peripheral nerves) and muscles. NINDS is committed to the study of the brain in Alzheimer's disease. In addition, NINDS research focuses on stroke, Huntington's disease, Parkinson's disease, and amyotrophic lateral sclerosis. NINDS is also conducting research on neuroimaging technology and molecular genetics to determine the etiology of Alzheimer's disease.

Recently, a NINDS-supported study revealed that treatment with the drug deprenyl delays the progression of symptoms in patients with early Parkinson's disease and postpones the need for L-dopa therapy. Although scientists are unsure how deprenyl works, they believe that this is the first treatment to actually slow the progress of the neurodegenerative disorder.

Stroke, the Nation's third-leading cause of death and the most widespread neurological problem, primarily affects the elderly. New drugs to improve the outlook of stroke victims and surgical techniques to decrease the risk of stroke currently are being studied.

(7) National Institute of Allergy and Infectious Diseases

The National Institute of Allergy and Infectious Diseases (NIAID) focuses on two main areas: infectious diseases and diseases related to immune system disorders.

Influenza can be a serious threat to older adults. NIAID is supporting and conducting basic research and clinical trials to develop treatments and to improve vaccines for high-risk individuals. Since older persons also are particularly vulnerable to hospital-associated infections, NIAID research is leading to a vaccine offering protection against one of the most common, difficult to control and often fatal infections, P. aeruginosa.

(8) National Eye Institute

The National Eye Institute (NEI) conducts and supports research and research training on the prevention, diagnosis, treatment, and pathology of diseases and disorders of the eye and visual system. The age 65 and older population account for one-third of all visits for medical eye care. Glaucoma, cataracts and aging-related maculopathy, which are of particular concern to the elderly, are being studied by NEI. Some of this research is intended to serve as a foundation for future outreach and educational programs aimed at those highest risk of developing glaucoma.

(9) National Institute of Arthritis, Musculoskeletal and Skin Diseases

The National Institute of Arthritis, Musculoskeletal and Skin Diseases (NIAMS) investigates the cause and treatment of a broad range of diseases, including osteoporosis and the many forms of arthritis. In 1988, the institute announced its support for the formation of nine specialized centers, which conduct research on rheumatoid arthritis, osteoarthritis and osteoporosis. The research centers, funded by Congress in 1987, will receive NIAMS funding for 5 years.

Affecting over 40 million Americans, these diseases are among the most debilitating of the more than 100 types of arthritis and related disorders. Older adults are particularly affected. Almost 50 percent of all persons over the age of 65 suffer from some form of chronic arthritis. An estimated 24 million Americans, most of them elderly, have osteoporosis.

Topics of research on the cause and treatment of rheumatoid arthritis, a chronic inflammatory disease of unknown cause, include the study of the immune cells present in the synovial fluid around arthritic joints, and the genetic basis for production of rheumatoid factor (an abnormal antibody found in the blood of patients with rheumatoid arthritis).

Research on osteoarthritis, a degenerative joint disease, focuses on changes in the network of surrounding cartilage cells in the joint.

(10) National Institute on Deafness and Other Communication Disorders

The National Institute on Deafness and Other Communication Disorders (NIDCD) conducts research into the effects of advancing age on hearing, vestibular function (balance), speech, voice, language, and chemical and tactile senses.

Presbycusis (the loss of ability to perceive or discriminate sounds) is a prevalent but understudied disabling condition. One-third of people age 65 years and older have presbycusis sufficient to interfere with speech perception. Studies of the influence of factors, such as genetics, noise exposure, cardiovascular status, systemic diseases, smoking, diet, personality and stress types, are contributing to a better understanding of the condition.

(11) National Center for Nursing Research

The National Center for Nursing Research (NCNR) conducts, supports, and disseminates information about basic and clinical nursing research through a program of research, training and other programs. Research topics related to the elderly include: depression among patients in nursing homes to identify better approaches to nursing care; physiological and behavioral approaches to combat incontinence; initiatives in areas related to Alzheimer's disease, including burden-of-care; osteoporosis; pain research; and the ethics of therapeutic decisionmaking.

2. NATIONAL INSTITUTE OF MENTAL HEALTH

As one of three Institutes of the Alcohol, Drug Abuse, and Mental Health Administration, the National Institute of Mental Health (NIMH) is involved in extensive research relating to Alzheimer's and related dementia, and the mental disorders of the elderly. NIMH is focusing on identifying the nature and extent of structural change in the brains of Alzheimer's patients to better understand the neurochemical aspects of the disease. NIMH research has discovered a protein specific to Alzheimer's that shows promise of being a positive diagnostic marker for the disease. Research into amnesia is also increasing knowledge about Alzheimer's and other dementia.

Depression is a relatively frequent and often unrecognized problem among the elderly, contributing to the high suicide rate within this population. Currently, white males over the age of 85 have the highest recorded suicide rate of any group in the population (55.8/100,000). Research has shown that nearly 40 percent of geriatric patients with major depression also meet the criteria for anxiety, which is related to many medical conditions, including gastrointestinal, cardiovascular and pulmonary disease.

NIMH has identified disorders of the aging as among the most serious mental health problems facing this Nation and is currently involved in a number of activities relevant to aging and mental health.

B. ISSUES AND CONGRESSIONAL RESPONSE

1. NIH APPROPRIATIONS

Congress, responding to what many feel is a crisis in biomedical research funding, gave NIH a large increase in the fiscal year 1991 appropriation. The fiscal year 1991 appropriation of nearly $8.28 billion is $700 million (9.2 percent) above the appropriation for fiscal year 1990. Most of the research institutes and other NIH entities received substantial increases beyond the amounts requested by the president. The additional funding will support some 1,200 additional new grants beyond the number of new grants started in fiscal year 1990.

Although several of NIH's authorities expired at the end of fiscal year 1990, no reauthorization legislation was passed by the 101st Congress. Both the Senate and House had considered measures that would have extended various programs and made numerous other changes and additions to NIH activities. The only elements of the bills that became law, however, were provisions establishing a new center for medical rehabilitation research and a National Foundation for Biomedical Research (P.L. 101-613).

Appropriation levels for the previously mentioned institutes at NIH involved with aging research are as follows:

FISCAL YEAR 1991 CONFERENCE ALLOWANCE FOR NIH

[Budget authority in thousands]

	Fiscal years—	
	1991	1990
Institute:		
NIA	$323,752	$239,452
NCI	1,714,784	1,634,294
NHLBI	1,126,942	1,072,335
NIDR	148,918	135,744
NIDDKD	615,272	581,466
NINDS	541,743	490,396
NIAID	906,251	832,960

FISCAL YEAR 1991 CONFERENCE ALLOWANCE FOR NIH—Continued

[Budget authority in thousands]

	Fiscal years—	
	1991	1990
NEI	253,241	236,529
NIAMS	193,247	168,927
NIDCD	134,935	117,582
NCNR	39,722	33,513

2. NIMH APPROPRIATIONS

NIMH's appropriation for mental health research for fiscal year 1991 is $484 million, up from $414 million in fiscal year 1990. The Appropriations Committee expressed support for NIMH's increased efforts related to the "Decade of the Brain" initiative, as well as its high-priority activities on Alzheimer's disease and schizophrenia.

3. ALZHEIMER'S DISEASE

Alzheimer's disease and other related dementias (ADRD) is rapidly becoming one of the most serious threats to the Nation's health and well-being. This progressive and irreversible degenerative brain disease is the fourth-leading killer in the United States. Despite research activity on Alzheimer's disease, no cure has yet been developed. Only through a continued commitment to research will this dreaded disease be cured and possibly prevented. For the first time, Federal appropriations for ADRD will surpass the $200 million mark in fiscal year 1991. This is a substantial increase above the fiscal year 1989 and fiscal year 1990 levels of $130 million and $148 million, respectively.

An epidemiological study by Denis Evans et al. for the first time gives a clear picture of the number of Alzheimer's patients in the elderly population. Previous figures often estimated that 2.5 to 3 million Americans were afflicted with Alzheimer's disease. The Evans study, supported by the National Institute on Aging, reports the number is now approximately 4 million Americans over the age of 65. This is 14 percent of the elderly population.

This study also found that the prevalence of Alzheimer's rose more rapidly with age than previously suspected. Overall about 10.3 percent of persons over age 65 living at home had Alzheimer's disease. Of those age 65 to 75, 3.0 percent had Alzheimer's disease compared to 18.7 percent of those age 75 to 84 and a striking 47.2 percent of those over age 85. Since those age 85 and older are the most rapidly growing sector of the population, the number of Alzheimer's patients is expected to dramatically increase to about 14 million persons in the year 2040 if nothing is done to prevent or cure the disease. As the prevalence of dementia escalates in the coming decades, so too will the costs—financial, physiological, psychological, emotional and personal.

A recent report by the Office of Technology Assessment (OTA), "Confused Minds, Burdened Families," has turned attention to the effects of ADRD on informal caregivers, such as family members.

Specifically, the report analyzes the problem of locating and arranging services for people with dementia and presents a framework for an effective system to connect them to services. As the awareness of Alzheimer's disease increases, appropriate services have been developed in many communities. However, the availability of these services is often fragmented. This report looks to a comprehensive system in which caregivers, families, friends, and even the patient's themselves can secure access to home care, adult day care, respite care, and other available services.

Congressional consideration of Alzheimer's disease has focused on increased funding for research on the causes, diagnosis and treatment of the disease. At present, there are no preventions or treatments, so concern is centering on the cost and ways of providing care for its victims. The burdens and costs of care are roughly $80 billion annually. This is only an estimate, however, because the social costs involved are extremely difficult to calculate. For example, the lost productivity and income of a spouse or other family members, and the increased incapacity of caregivers are difficult to measure in dollar amounts. With growing numbers of older persons susceptible to the disease, associated costs could reach almost catastrophic proportions early in the next century.

Most of the federally funded research into Alzheimer's disease is being carried out by the National Institute on Aging, National Institute of Neurological and Communicative Disorders and Strokes, the National Institute of Allergy and Infectious Disease, the National Eye Institute, and National Center for Nursing Research, the National Institute of Mental Health, the Health Care Financing Administration (HCFA), and the Administration on Aging (AoA). The AoA has supported research and demonstration programs to develop and strengthen family and community-based care for Alzheimer's disease victims.

A great deal of progress has been made recently in the understanding of the cellular and chemical basis of the disease. Studies on the molecular genetics of Alzheimer's disease indicate a linkage between chromosome 21 and the familial or early onset of Alzheimer's disease. Other important findings point to the potential for biomedical diagnostic tests based on the detection of specific biological markers. Other avenues being explored include enzyme deficiencies, abnormal neurons, a slow virus, an abnormal protein, a genetic defect, a defect in calcium regulation inside the nerve cell, and an accumulation of aluminum in the brain.

Research into treatment of the disease has focused on testing drugs for treating Alzheimer's major symptoms—loss of memory and intellect. No drugs have yet been tested that might stop the underlying process of the disease. Many of the drugs under investigation increase the amount of acetylcholine in the brain. Currently, NIA is sponsoring clinical trials on the safety and efficacy of tetrahydroaminoacridine (THA), an experimental drug that may help control memory loss. The study, begun in 1987, was temporarily suspended when 20 of the first 50 patients enrolled in the drug trial developed toxic liver problems. The doses of THA were subsequently reduced and the experiment continued with plans to enroll up to 300 patients. The results will be published in the spring of 1991.

The Alzheimer's Disease Research Centers are an important component of the national effort to find a cause and cure for this disease. Since funding began in 1984 through grants from the National Institute on Aging (NIA), the centers have established special units for clinical and basic research, as well as for behavioral studies of Alzheimer's and related disorders. NIA currently funds 15 centers. Based primarily at universities and hospitals, the centers also train scientists and health care providers, and fund new research projects. Guidelines for the centers were developed by NIA along with the NIMH, the NINCDS, and the NIAID.

Congress passed the Alzheimer's Disease and Related Dementias Services Research Act of 1986 as part of the Omnibus Health Bill (P.L. 99-487). This legislation established, within the HHS, the Council on Alzheimer's Disease to coordinate research on Alzheimer's disease and related dementias and the care of individuals with dementia.

In addition, OBRA 1986, authorized up to 10 Medicare demonstration projects, with an appropriation of $40 million over 3 years, through which a limited number of Alzheimer's patients would receive benefits not previously covered by Medicare. This demonstration began on May 15, 1989. Eight cities are participating: Rochester, NY; Miami, FL; Cincinnati, OH; Memphis, TN; Portland, OR; St. Paul, MN; Urbana, IL; and Parkersburg, WV. Services being provided and paid for under Part B of Medicare include case management, adult day care, homemaker and personal care, mental health, and education and counseling for caregivers. Two different models of case management are being tested in the demonstration: one in which the demonstration sites receive up to $300 a month for services for each patient, and each case manager works with 100 patients, and another model in which the demonstration sites receive up to $500 a month for services for each patient, and each case manager works with 30 patients. Beneficiaries are responsible for 20 percent of this amount.

To date, no conclusions have been reached concerning the effectiveness or impact of the expanded services and case management. This is primarily due to the difficulty that the demonstration sites experienced in enrolling patients. According to a recent OTA report on Alzheimer's disease, this difficulty may reflect the reluctance of patients and their family and friends to acknowledge the existence of Alzheimer's disease. The demonstration will run for 3 years, and after completion, an evaluation of the project will be published by the HCFA.

The Advisory Panel on Alzheimer's Disease, established under Public Law 99-660, released its 1990 annual report in January of 1991. This is the second in an ongoing series of annual reports, which contain public policy and science policy recommendations for administrative and legislative actions in the areas of health services, biomedical research, and the financing of health care benefits for Alzheimer's disease victims.

The first report contained a series of recommendations regarding biomedical research, health services research, organization and delivery of services, and financing of care. The second report provides an expanded, detailed examination of options available to finance the care of Alzheimer's disease patients. In addition, this report addresses the chronic shortage of staff trained to respond to the special needs of Alzheimer's disease patients.

4. ARTHRITIS AND MUSCULOSKELETAL DISEASES

The National Institute of Arthritis and Musculoskeletal and Skin Diseases (NIAMS) conducts the primary Federal biomedical research for arthritis and osteoporosis. Support research for these disorders is also carried out by the NHLBI, the National Institute of General Sciences, the NCNR, and the Office of the Director, NIH.

Osteoporosis is a major debilitating health problem for an estimated 24 million Americans—half of all women over age 45 and 90 percent of women over age 75. Although the majority of osteoporosis victims are women, men constitute approximately 20 percent of all people with the disease. Osteoporosis, characterized by chronic loss of bone mass, leads to an increased risk of hip, neck, and wrist fractures, immobility, disability and, sometimes, death. Medical costs, now estimated at $10 billion annually, will increase significantly as the population ages and incidence increases.

Every year, osteoporosis is responsible for 1.3 to 1.5 million bone fractures in those over age 45, or about 70 percent of all bone fractures in that age group. Forty percent of the people who suffer a hip fracture will never recover full independence. The costs to the health care system of hip fractures alone to people over age 64 is about $8 billion a year. By the year 2020, if no preventive measure or cure is discovered, the annual cost will rise to $14 billion (in 1987 dollars). Most of the approximately 250,000 hip fractures suffered by individuals over age 45, in 1988, were attributable to osteoporosis. This specific type of fracture often has catastrophic outcomes. According to a recent OTA report, some 12 to 20 percent of people who have hip fractures die as a result of the fracture and related complications.

The second international osteoporosis conference, "Research Advances in Osteoporosis," was held in Washington, DC in February 1990. Leading researchers reviewed new research into the cause of osteoporosis, including the role of growth factors in bone formation. According to the National Osteoporosis Foundation (NOF), a cosponsor of the program, new bone mass measurement techniques that determine bone density can help decrease the debilitating and sometimes fatal consequences of osteoporosis.

A task force, commissioned by NOF, found that bone mass measurement is a cost-effective means of identifying certain individuals at risk for osteoporosis. They conclude that single photon absorptiometry, dual photon absorptiometry, dual energy x-ray absorptiometry, and quantitative computed tomography are accurate means of measuring bone mass and that these can influence recommendations for treatment.

Treatment of a fracture, as a result of osteoporosis, is most often addressed with rehabilitation. This can improve mobility, but to date there is no proven method for restoring bone mass in a person once osteoporosis is detected. Therefore, prevention is the primary focus of biomedical research. Medical experts agree that osteoporosis is highly preventable through early screening, balanced diet, regular exercise, limited intake of alcohol, and no smoking of tobacco.

The latest scientific consensus on osteoporosis recognizes estrogen and calcium deficiencies as the major causes of postmenopausal osteoporosis. It has recently been discovered that bone cells contain receptors for estrogen and that estrogen treatment in postmenopausal women can protect against hip fractures in later years, although there is concern about the possible risks involved with this treatment.

A number of experimental therapies to prevent and treat osteoporosis are being studied. Such treatments include the class of medication known as diphosphonates, such as etidronate, that coat bone crystal and prevent the process of bone resorption. This treatment could be helpful to patients with established osteoporosis. Clinical trials are currently underway for this promising treatment, which is comparatively inexpensive and safe.

In addition to research in osteoporosis, NIAMS is the primary research institute for arthritis and related disorders. Arthritis, an inflammation of the joints, is used to describe the more than 100 rheumatic diseases. Many of these disorders affect not only the joints, but other connective tissues of the body as well. Approximately 1 in 7 persons has some form of rheumatic disease, making it the Nation's leading crippler. Although no cure exists for the many forms of arthritis, progress has been made through clinical and basic investigations. The two most common forms of arthritis are osteoarthritis and rheumatoid arthritis.

Osteoarthritis (OA), a degenerative joint disease, affects more than 16 million Americans. OA causes cartilage to fray, and in extreme cases, to disappear entirely, leaving a bone-to-bone joint. Disability results most often from disease in the weight-bearing joints, such as the knees, hips, and spine. Although age is the primary risk factor for OA, age has not been proven to be the cause of this cripping disease. NIA is focusing on studies that seek to distinguish between benign age changes and those changes that result directly from the disease. This distinction will better allow researchers to determine the cause and possible cures for OA.

Rheumatoid arthritis (RA) is a chronic inflammatory disease affecting more than 2.1 million Americans, two-thirds of whom are women. RA causes joints to become swollen and painful, and eventually deformed. There are no known cures for RA, but research has discovered a number of therapies to help alleviate the painful symptoms. Guanethidine, a regional nerve blocker, has been found to decrease pain and increase finger-pinch-strength in patients with active RA. Another drug, cyclosporin A, lessens the pain and swelling of the joints. Its toxicity to the kidney and elsewhere, however, limits its therapeutic value.

5. PHYSICAL FRAILTY: THE LOSS OF INDEPENDENCE

Physical frailty severely impairs strength, mobility, balance, and endurance. It occurs in millions of older people and often leads to serious falls, nursing home admissions, and a loss of independence. In April of 1990, NIA and NCNR awarded $2.9 million for clinical trials aimed at reducing and possibly preventing physical frailty in older persons. The trials, known as Frailty and Injuries: Cooperative Studies of Intervention Techniques (FICSIT), will extend over 3 years and involve a combination of exercise, nursing, prevention, and rehabilitation techniques. According to Dr. T. Franklin Williams, director of NIA, "the new trials highlight the fact that frailty and injuries are not the inevitable outcome of aging. Instead they are problems for which we have now found some very viable solutions."

Researchers are optimistic that one of the benefits of FICSIT will be a reduction in health care needs and costs. Frailty not only increases care needs because of the loss of independence, it also increases the risk of falls, the most common cause of injury in older persons.

6. GERIATRIC TRAINING AND EDUCATION

Essential to effective, high quality, long-term and other health care for the elderly is an adequate supply of well-trained health care providers, including physicians, physicians' assistants, nurses, dentists, social workers, and gerontological aides. For decades, the Federal Government has supported the education and training of health care professionals by providing financial assistance through a variety of Federal and State agencies. This support was relatively unrestricted and unfocused, aimed at increasing the numbers of all types of health care professionals.

By the mid-1970's, this generalized effort had proven successful. Congress then focused on particular problem areas in the supply of health care professionals, such as geographic and specialty shortages. For example, special trainee and residency programs were established for preventive, family and general internal medicine, physician assistants, and minority health education.

Congress now is beginning to focus more attention on training and education for geriatric care, although funding still is limited. The Health Professions Special Education Initiatives Program has been established by Congress to carry out high-priority initiatives in the national interest. Funding has been awarded to schools and other institutions that train health professionals for special educational training programs in geriatrics, health economics, health promotion and disease prevention, and computer-simulated medical procedures.

Under this initiative, geriatric education centers (GEC's) provide short-term multidisciplinary faculty training, curriculum, educational resource development, and other assistance in affiliation with other educational institutions, hospitals, nursing homes, Veterans' Administration hospitals, and community-based centers for the elderly. Many GEC's also serve as geriatric evaluation units which provide clinical training. Congress also has initiated a new trainee and fellowship program under the Public Health Service Act to initiate in-depth training of faculty in geriatrics for the later training of future health care providers in geriatrics.

Although the Federal Government is beginning to recognize the current and future need for health care professionals trained in geriatric care, it has yet to appropriate significant funding for geriatric education and training. This lack of funding poses a dilemma for an aging society in which demands for geriatric and related services by those age 65 and older are increasing at an unprecedented rate. In a 1987 report, "Personnel for Health Needs of the Elderly Through Year 2020," the National Institute on Aging (NIA) projected that by 2020 use of services by the elderly population will be more than twice the 1980 volume.

NIA also predicted that older adults will compose up to two-thirds of the practices of most physicians and other health caregivers. Primary care practitioners in family and internal medicine are expected to continue to provide most of the medical care for the aged. NIA also predicted that the demand for personnel specifically prepared to serve older people will greatly exceed the current supply.

If current medical school enrollments remain stable, the number of practicing physicians in the year 2020 will be approximately 850,000. NIA estimates that the annual rate of increase of physician supply between 1985 and 2020 will be slightly less than the comparable growth rate of the elderly population during that period. An estimated 14,000 to 29,000 geriatricians may be needed by 2020, according to the study.

The most serious shortage is in the number of faculty members and other leaders who have specialized backgrounds in aging and geriatrics and who can develop and teach undergraduate, graduate, in-service and continuing geriatric education programs. The report stated that only 5 to 25 percent of the teaching faculty and researchers estimated to be needed to develop sufficient education training programs are currently available.

Among the most critical health care issues for the elderly in the future are the personnel and training needs for caregivers who work with residents in nursing homes. Projections through the year 2000 of the need for full time registered nurses in nursing homes range from 260,000 (about three times the staffing levels in 1983-84) to 838,000. The estimates of demand for other licensed nursing personnel range from 300,000 to 339,000 and for nursing aides, the prediction is that 1 million will be needed by the year 2000.

Inadequate training is one of the many problems facing workers in nursing homes and private homes, according to the Older Women's League. These 1.5 million workers, mostly women, and mostly middle-aged, receive little or no training, according to its 1988 report, "Chronic Care Workers: Crisis Among Paid Caregivers of the Elderly."

The Health Omnibus Extension Act (P.L. 100-607) also included the Health Professions Reauthorization Act of 1988, which reauthorized the program that provides grants and contracts to geriatric education centers (GECs) and for geriatric training projects to train physicians and dentists who plan to teach geriatric medicine or geriatric dentistry. $7 million was authorized for each program for fiscal year 1989, $10 million for fiscal year 1990, and $13 million in fiscal year 1991. Under the GEC provisions, grants and contracts can be provided to health professions schools, including *schools of allied health.*

The appropriations bill for fiscal year 1991 provided $13.7 million for geriatric training programs, a decrease of $0.3 million from fiscal year 1990.

7. SPECIAL POPULATIONS

Two groups have been organized under the National Institute on Aging (NIA) to help further research on issues of minority aging: the NIA Staff Work Group on Minority Aging; and the Task Force on Minority Aging, a subcommittee of the National Advisory Council on Aging. While most of the aging research supported by NIA has important implications for all ethnic and cultural populations, only about 2 percent of the NIA research budget is spent on issues of special relevance to the aging of minorities.

The work of these two groups has resulted in a number of research and training initiatives to increase research on minority health. NIA will issue a series of "Request for Applications" (RFAs) on research areas of relevance to minority aging. Some of the areas for research include: the relationship of disease severity to specific types of functional impairment in individual minority populations; intergenerational relationships and the family structure; long-term care of minority elderly; and religious organizations as a source of support for minority elderly. NIA is a co-funder in the Minority Biomedical Research Support Program (MBRS), which supports projects on molecular aspects of aging, as well as studies of social relationships in aging.

In addition to promoting research on minority health issues, NIA has developed a series of initiatives to increase the number of minorities involved in research activities. An additional slot to be used for minority trainees has been added to the funded institutional training grants. Also, the Institute plans to develop a program of dissertation grant support in minority aging issues, with priority to minority graduate students.

Compared with either minority men or nonminority men and women, older minority women are more likely to be impoverished, suffer greater disabilities, and live alone. Little research, however, is available on the circumstances disadvantaging minority women, or on their needs for health care and other services. Even the contributions of older minority women to their families and communities, through child and elder care, are poorly documented or understood. Therefore, special attention should be given by NIH to this special population of older minority women, through both minority and women's research initiatives.

Much concern has been raised recently about whether women have been adequately and appropriately represented in NIH's intramural and extramural clinical trials. A 1990 analysis by the GAO has heightened this concern. Women constitute approximately 59 percent of the age 65 and over population, and about 72 percent of those age 85 and older. Given the preponderance of women in the older age groups, particular interest in supporting the health and well-being of older women should be a priority of NIH, particularly NIA. Current research in the following areas is a particular concern to women: menopause, osteoporosis, frailty and disability, cancer, preventive health behaviors, women caregivers, work and retirement, and women in rural areas.

NIH should review its policy on special populations to ensure that adequate representation by minorities and women is achieved consistently throughout all of the Institutes of Health. In addition, the focus on the special populations should apply to both intramural and extramural research activities.

8. Research on the Burdens of Caregiving

Most long-term care is provided by families at tremendous emotional, physical and financial cost. The National Institute on Aging (NIA) conducts extended research in the area of family caregiving and strategies for reducing the burdens of care. Research is beginning to describe the unique caregiving experiences by family members in different circumstances: many single older spouses, for example, are providing round-the-clock care at the risk of their own health; and adult children are often trying to balance the care of their aged parents, as well as the care for their own children.

Families must often deal with a confusing and changing array of formal health and supportive services. For example, older people are currently being discharged from acute care settings with severe conditions that demand specialized home care. Respirators, feeding tubes, and catheters, which were once the purview of skilled professionals, are now commonplace in the home.

The employed caregiver is becoming an increasingly common long-term care issue. This issue came to the forefront during legislative action on the "Family and Medical Leave Act." While many thought of this only as a child care issue, elderly parents are also in need of care. Adult sons and daughters report having to leave their jobs or take extended leave due to a need to care for a frail parent.

While the majority of families do not fall into this situation, it will be a growing problem. Additional research is needed to balance work obligations and family responsibilities. A number of employers such as AT&T, Stride-rite, and Travelers have begun to design innovative programs to decrease employee caregiver problems. Some of these include the use of flex-time, referral to available services, adult day care centers, support groups, and family leave programs.

While clinical research is being conducted to reduce the need for long-term care, a great need exists to understand the social implications that the increasing population of older Americans is having on society as a whole.

C. PROGNOSIS

Congress, responding to what many feel to be a crisis in the Federal support for biomedical research, gave NIH a large increase in the fiscal year 1991 appropriation, to $8.28 billion. NIA received the largest percent increase of any of the Institutes. It increased its funding from $239 million in fiscal year 1990 to $323 million for fiscal year 1991.

Within the past 50 years, there has been an outstanding improvement in the health and well being of the American people.

Some once deadly diseases have been controlled or eradicated, and the survival rates for victims of heart disease, stroke, and cancer have improved dramatically. Many directly attribute this success to the Federal Government's longstanding commitment to the support of biomedical research.

The demand for long-term care will continue to grow as the population ages. Alzheimer's disease, for example, is projected to double before the end of the century and quadruple by the year 2040 if biomedical researchers do not identify the cause and develop effective treatments. For the first time, however, Federal appropriations for Alzheimer's disease research will surpass the $200 million mark. The increased support for this debilitating disease indicates a recognition by Congress of the extreme costs associated with Alzheimer's disease. It is essential that the appropriation level for aging research remains consistent in order to follow promising research that could lead to treatments and possible prevention of ADRD and many other costly diseases, such as cancer and diabetes.

Various studies have highlighted the fact that although research may appear to focus on older Americans, benefits of the research are reaped by the population as a whole. Much research, for example, is being conducted on the burdens of caregiving on informal caregivers. Research into the social sciences needs to be expanded as more and more families are faced with caring for a dependent parent or relative.

Finally, research must continue to recognize the needs of special populations. Too often, conclusions are based on research that does not appropriately represent minorities and/or women. Expanding the number of grants to examine special populations is essential in order to gain a more complete understanding of such chronic conditions as Alzheimer's disease, osteoporosis, and Parkinson's disease.

Chapter 10

HEALTH BENEFITS FOR RETIREES OF PRIVATE-SECTOR EMPLOYERS

OVERVIEW

Following the enactment of Medicare in the mid-1960's, the prevalence of employer-sponsored retiree health benefit packages increased dramatically. Once Medicare was established, employers could offer health benefits to their retirees with the assurance that the Federal Government would pay for many of the medical costs incurred by company retirees age 65 and older. Since that time, retiree health benefits have become a common provision of private employer plans and a major source of Medicare supplemental insurance among retirees.

Because these benefits commonly lack an adequate funding mechanism retiree health plans represent large unfunded liabilities to employers. The absence of benefit security has lead to a growing concern over whether employers can meet these obligations. Such concerns are compounded by the rising costs of health care, which drive up employer liabilities in this area. If employers cut back or cancel their retiree health plans in response, retirees will lose an important source of privately sponsored health insurance.

A. BACKGROUND

Many employers sponsor group health insurance plans that supplement Medicare benefits for retirees age 65 and older and provide coverage for retirees not yet eligible for Medicare. Medicare, which covers 33 million Americans, provides fundamental health insurance for nearly all Americans age 65 or older. However, Medicare neither meets all of the health care needs of these retirees, nor covers those who retire before age 65. As a result, employer-sponsored retiree health plans represent an extremely important source of health insurance protection for retirees.

Although privately sponsored retiree health benefits are far from universal, they are nevertheless a major source of health coverage for a large number of retirees. According to a 1990 General Accounting Office (GAO) report, over 5 million retired workers are provided such coverage, including 2 million who are under age 64. Nearly 80 percent of companies with retiree health benefits cover early retirees, or those workers who retire before age 65, while over 60 percent extend coverage regardless of age. Because early retirees are not covered by Medicare, coverage through their former employer is especially important.

Yet, measured another way, GAO found that only about 105,000 companies, or 4 percent of the total, extended health benefits to their retired workers beyond the period required by the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). Under COBRA (P.L. 99-272), employers are required to allow retiring and other former workers to continue to participate in the company's group health plan for a limited period of time, usually 18 months, at the former worker's expense.

In the same 1990 study, GAO reported that the availability of retiree health benefits generally decreased dramatically with the size of a company. As little as 2 percent of companies with a work force of 25 or less provide health coverage following retirement. Companies in this size range make up 85 percent of all companies.

At the same time, because more workers are employed by larger companies GAO added that far more workers may become eligible for retiree health coverage than the number of companies with retiree health coverage might suggest. About 73 percent of workers are employed by companies with 100 workers or more. Approximately 38 million workers—40 percent of an estimated total of 96 million workers—are employed by companies with retiree health benefits.

When measured against the total number of older Americans, the extent of retiree health coverage is less impressive. According to Department of Labor (DOL) reports, only one out of every six Americans age 65 or older in 1983 received a portion of his or her health coverage from an employer or union. In that year, approximately 6.9 million retirees were covered by private employer or union sponsored health plans, with 4.3 million of these retirees age 65 or older and 2.6 million under age 65. According to other reports, approximately 25 million of the Nation's workers—representing 34 percent of the national labor force—were employed by companies that sponsor retiree health benefit plans.

For those who have employer-provided coverage, retiree health benefits are very important. Because the cost of purchasing an individual policy following retirement is often prohibitive the opportunity to continue participating in the employer's group plan can represent a significant savings for a retired worker. As a result of lower administrative costs and employer contributions, group insurance plans typically offer to beneficiaries a higher range of benefits at a lower cost than would be available under individual policies. For retirees under age 65, an individual plan can be extremely costly, and for those age 65 or older with a pre-existing medical condition it also may be very difficult to find.

Those employers who provide coverage for retired employees and their families in a group health plan generally provide full coverage in the company's plan until age 65. At that point, most companies provide comprehensive health coverage related directly or indirectly to the benefits provided by Medicare. Under these plans, one of three approaches may be used: A "carve-out," "Medicare supplement," or "coordination of benefits" plan.

Most commonly offered to retirees is the carve-out plan. This type of health care approach provides for continued retiree coverage under a group plan, but does not cover services for which Medicare will pay, thus avoiding duplicate coverage. Because retirees share their costs through co-payments and deductibles, carve-out plans tend to be the least costly for employers.

A variation of the carve-out approach, the so-called coordination of benefits plan pays what it would in the absence of Medicare, but limits payments to 100 percent of the cost actually incurred. Because this type of plan pays for services not covered by Medicare, its costs are affected by changes in Medicare coverage.

Unlike the coordination of benefits plan, a Medicare supplement type of retiree health care plan is insulated from changes in Medicare coverage by specifying exactly what costs are covered. The plan can tailor benefits to the needs of the retiree and also may result in a change in benefits when an early retiree reaches age 65. Although the costs of a Medicare supplement can be more easily controlled, this approach requires the design and administration of a separate plan.

B. ISSUES

1. Protection for Retirees

Traditionally, employers have not prefunded health benefits plans, preferring instead to handle these obligations on a pay-as-you-go basis. In fact, many employers still do not appear to fully recognize the potential financial implications of their health benefit plans. Estimates of current unfunded liabilities for employee health benefits range from $100 billion, according to the DOL, to $221 billion, according to the GAO. The GAO estimates that it would require $402 billion in investment today by employers to pay for the health benefits of current and future retirees.

Following LTV Corporation's filing for reorganization under Chapter 11 of the U.S. Bankruptcy Code in 1986, there was a sharp increase in congressional concern over retiree health benefits. As part of the company's bankruptcy, LTV moved to terminate the health and life insurance benefits of more than 78,000 of its retirees. In response to this crisis, the Congress was confronted with the larger and more difficult question of whether other companies would provide the health care coverage promised to their retirees, or simply terminate their plans in the event of similar financial difficulties.

The LTV bankruptcy highlighted the problems surrounding the enormous unsecured promise of health benefits made to retirees across the Nation. In the case of LTV, a retaliatory strike by the Steelworkers and Federal legislation forced the corporation to reinstate health benefits for 6 months. Congress also included provisions in the Tax Reform Act of 1986 (P.L. 99-514) that permitted LTV to use certain tax benefits to fund the purchase of health and life insurance benefits. However, this incident spurred the Congress to enact legislation aimed at protecting other retirees who found themselves in similar straits. Included were provisions in (1) COBRA of 1985, requiring an 18-month continuation of health benefits to retirees who otherwise would lose their health coverage upon retirement; (2) the Omnibus Budget Reconciliation Act of 1986 (OBRA), Public Law 99-509, requiring that companies entering Chapter 11 bankruptcy after July 1, 1986, continue health coverage for their retiring or retired employees for life, as well as coverage for their spouse and dependent children for 3 additional years in the event of their death; and (3) the continuing appropriations resolution for fiscal year 1986 (P.L. 99–591), requiring that the health and life benefits being paid by companies in Chapter 11 bankruptcy as of October 2, 1986, continue to be paid until May 15, 1987. Under provisions in the Retiree Benefits Bankruptcy Protection Act of 1988 (P.L. 100–334), the last provisions were extended. These provisions apply to Chapter 11 cases in which a reorganization plan had not been confirmed by a court and in which such benefits were being paid on October 2, 1986, and thereafter.

Retirees have looked to the Federal courts for protection of their employer-sponsored health benefits although with results that ultimately have not provided assurances to them. In the earlier decisions, however, the courts were generally sympathetic to retirees. In *Eardman* v. *Bethlehem Steel Corp.* [607 F. Supp. 196 (1984)], 16,000 non-union retirees objected to changes in their medical plans which were instituted by Bethlehem Steel to contain costs. A U.S. district court, reviewing the terms of these plans held that where employers did not clearly retain the right to reduce or cancel retiree benefits these benefits could not be reduced. After filing an appeal, Bethlehem agreed to provide a permanent health program for the retirees by combining features of the original and modified medical plan.

During this same period, a Tennessee case, *Musto* v. *American General Corp.* [615 F. Supp. 1483 (1985)], went even further. While *Bethlehem Steel* had implied that employers were free to modify retiree benefits if those retirees had been informed of the possibility prior to leaving their job, *Musto* prohibited modification by the employer regardless of what employees or retirees had been told. *Musto* held that employer health benefits vest upon retirement and were unchangeable thereafter regardless of the reservation clauses employers may have incorporated into plan documents.

Some hailed the lower court's decision in *Musto* as a far-reaching development in the protection of retiree health. Others, however, including the Washington Business Group on Health (WBGH), raised concerns that a prohibition against any change in retiree health plans would prevent employers from adopting plan modifications that would help to contain escalating health care costs and increase the quality of care provided. The WBGH warned that depriving employers of the ability to modify plans in any way would have the effect of locking in plans that were outmoded and wasteful, and would impose the entire burden of cost containment on future retirees.

Although *Musto* represented an initial victory for retirees, the higher courts took a far narrower view of the extent to which employers are obligated to provide health benefits. On November 15, 1988, the 6th U.S. Circuit Court of Appeals reversed *Musto* [861 F. 2d 897 (6 Cir. 1988)], holding that retirees have no vested right to health benefits where employers explicitly reserve the right to modify the terms of those benefits.

The court ruling in another case, *Hansen* v. *White Farm Equipment Co.,*[1] had similar implications for retiree health benefits. In this case, the company cancelled retiree medical coverage when it filed for Chapter 11 reorganization. Previously, a U.S. district court had reversed a bankruptcy court decision and held that the company had to continue coverage because retirees had a vested right to their health benefits at retirement, and because the clause the employers had included in the plan to reserve the right to terminate benefits had not been sufficiently clear.[2] On appeal, however, the court reversed this decision, holding that while retirees do have contractual rights in post-employment benefits, they are not automatically vested upon retirement and are subject to any limitations included in the contract.[3] The court held that only Congress, not the Federal courts, has the power to declare retiree medical benefits vested. The case was remanded to the bankruptcy court for a determination as to whether the information conveyed to the retirees clearly and expressly reserved the right of the company to terminate benefits.

As a result of these reversals, the courts are in agreement that retiree health benefits are not a vested right and are subject to modification in accordance with the terms of the employer-employee contract.

2. FUNDING OF RETIREE BENEFIT PLANS

In recent years, employer concerns over the financial burden retiree health benefits represent have mounted. Rapidly rising health care costs have forced employers to recognize that more and more financial resources will be needed to provide health benefits to retirees in the future, particularly for companies with a high ratio of retirees to employees. Employers also are concerned that the Federal Government, in its efforts to contain costs under Medicare, will make changes in Medicare policy that shift more health care costs to employers.

There is also a growing recognition among financial markets that retiree health plans represent current liabilities which must be counted against company earnings. Until 1985, companies were not required to include the financial liabilities associated with a retiree health plan in a financial statement. In fact, at that time few companies had any idea what their total liability was for providing the health care benefits promised to their future retirees.

However, in 1984, the Financial Accounting Standards Board (FASB)—an independent, nongovernmental group which develops standards for financial reporting—for the first time required plan disclosure of plan liabilities, effective 1985. More specifically, employers are required to disclose a footnote on their annual balance sheet information concerning how, or whether, their health benefits plans are prefunded. More recently, in January 1989 FASB released for comment a set of more comprehensive draft rules to require companies to report both current and accrued expenses associated with retiree health benefits. FASB's final rule was issued in late 1990, but most plans will not be affected until 1993.

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[1] 23 Bankruptcy Reporter 85 (1982).

[2] 42 Bankruptcy Reporter 1005 (1984).

[3] *Hansen* v. *White Motor,* 788 F.2d 1186 (6th Cir. 1986).

By focusing on the adequacy of employer prefunding of such benefits, some financial analysts believe that FASB's reporting requirements may significantly affect the financial standing of companies with large unfunded liabilities. According to these analysts, investors have paid scant attention to the retiree health plan liabilities of companies. Because companies would have to reveal these liabilities under the rules, however, their attractiveness to potential investors could be diminished as a result. Particularly for companies that are financially strained, this reporting requirement could have this effect. However, others on Wall Street assert that they have been aware of companies' liabilities and have been taking them into account all along.

At present, relatively few employers prefund their plans. Some employers feel that they are legally obligated to provide promised retirees health benefits and therefore should prefund their plans. Others, however, resist accepting these obligations and the notion of prefunding.

Prefunding will remain an unattractive option for employers until tax incentives are provided that offer favorable treatment for setting aside funds to pay for future health benefits—similar to the favorable tax treatment that pension contributions currently receive. At present, however, the Federal Government appears unwilling to provide tax breaks to help offset the costs of funding these benefits without some minimum standards guaranteeing that retirees would be eligible for specified minimum benefits.

Indeed, as a result of provisions in the Deficit Reduction Amendments of 1984 (DEFRA), one tax mechanism for prefunding of employer-sponsored health benefits was significantly scaled back, effective January 1986. Previously, that law had allowed employers to establish a voluntary employee benefit association (VEBA) into which they could set aside unlimited funds to provide for retiree health benefits. To receive a tax deduction for these funds, the employer only had to certify that the funds would be used to pay for benefits. However, the Treasury Department persuaded the Congress that although the VEBA mechanism was not widely used, unlimited deductions were not appropriate for "contributions" which faced neither reporting and disclosure requirements, nor limitations on total funding.

In effect, the DEFRA provisions put the burden of justifying the need for a tax-favored funding mechanism for retiree health benefits on the employer. Also, the law placed a cap on the amount of funds that an employer could set aside for tax purposes, thus decreasing the value of VEBA's as a prefunding mechanism. At present, no more can be set aside than the total of a company's current expenditure for a particular benefit, plus 75 percent of that amount to account for future uncertainties. The 75-percent limit, according to benefit consultants, is far below the amount needed to account for increases in the size of the retiree population and the rapidly escalating costs of health care.

C. CONGRESSIONAL RESPONSE

In the 101st Congress, legislation was introduced to permit employers to use excess pension funds to pay for health benefits of current retirees. The issue was given momentum in the following year when the Administration included as part of its FY 1991 budget a proposal to permit employers to transfer excess pension funds into company retiree health accounts. After consideration of various legislative approaches to address this issue, legislation was ultimately agreed to that permits employers to use excess pension funds to pay for the health benefits of current retirees. That legislation was included in the Omnibus Budget Reconciliation Act of 1990 (P.L. 101-508).

D. PROGNOSIS

To date, Federal legislation has sought to protect retirees in the event of a company's filing for bankruptcy under Chapter 11. In addition, employers have been granted permission to use excess pension funds to help pay for the health benefits of current retirees. Yet, as long as health care costs continue to sharply rise, Congress will remain concerned about the ability of employers to make good on promises to provide health benefits to future retirees.

In 1991 and beyond, Congressional activity in this area will likely focus on concerns over the impact of the FASB rule requiring employers to count unfunded retiree benefit liabilities against company earnings. Most companies must comply with the rule in 1993.

The FASB rule will place significant pressure on employers to prefund retiree health plans. In response, employers may seek tax incentives from the Congress to help offset the costs of funding retiree health plans. Congress may also monitor any efforts by employers to lessen the liability of such plans by cutting back or eliminating retiree health plans.

Chapter 11

HOUSING PROGRAMS

OVERVIEW

In the final days of the 101st Congress, the Cranston-Gonzalez National Affordable Housing Act (NAHA 1990) was signed into law (P.L. 101-625). This measure was the first comprehensive housing act since 1974. The Act was formed through the reconciliation of three major efforts: the Senate proposals for increased involvement at the State and local level; the House proposal to strengthen and improve existing housing programs; and the Bush administration's Homeownership and Opportunity for People Everywhere (HOPE) initiatives to promote the sale of public and other federally assisted housing to its tenants. The new housing law reaffirms the long established national commitment to provide decent, safe, and sanitary housing for every American.

As the Federal funds for housing programs dwindled under the budgetcutting measure of the 1980's, the number of homeless families and individuals increased, fewer families were able to purchase homes, construction levels dropped, and special populations, such as the elderly, found themselves on the waiting list for assisted housing often for more than 2 years.

The need for housing for the elderly, particularly those with low and moderate incomes, continues to increase to a large extent because of the Nation's steadily growing elderly population. Current demographic projections indicate that the number of households headed by older persons is rising steadily. More than one-fifth of all U.S. households today—approximately 17 million—are headed by persons 65 years of age or older. Seven million are headed by persons over 75. From 1980 to 1995, the percentage of households headed by persons over 65 will rise by 33 percent and those headed by persons over 75 will increase 52 percent. It is projected that by 1995, 21.4 million households will be headed by Americans over 65.

In addition, the rapidly growing need for special living arrangements and supportive services for older persons, whose abilities to live independently have diminished, is increasingly recognized as a significant social policy concern. Increasing numbers of frail older persons, particularly those over 75 years of age, with mild to moderate impairments in their activities of daily living, are "aging in place" in federally assisted housing and other publicly supported housing units. In the absence of key supportive services, ranging from meals to varioius therapies, these individuals face the likelihood of having to leave their homes for other, typically more restrictive, living environments, including nursing homes.

The majority of the elderly have equity in their homes that could help in meeting their housing costs. Three out of every four elderly-headed households own their homes; more than 80 percent of them mortgage free. For many, their home is their only asset. These factors have contributed to the growing interest in innovative housing arrangements, such as home equity conversion plans.

Until 1981, the Federal Government had been substantially increasing its involvement in the production of housing for the low-income elderly. Since that time, however, Federal activity in the area of housing, particularly in the production of new units, has fallen off dramatically. There has been a change in Federal policy from an emphasis on long-term commitment in the form of construction of new housing and the rehabilitation and modernization of older housing, to shorter-term commitments emphasizing the use of existing housing stock through vouchers, for example.

The largest decline in Federal programs has been in budget authority for the assisted housing category, down from $25 billion in fiscal year 1981 to $7.3 billion appropriated for fiscal year 1991. However, because actual spending for these programs is spread over a long period of time—20, 30, or even 40 years—cuts in budget authority are slow to result in reductions in outlays or actual spending. Thus, in spite of substantial reductions in budget authority, actual outlays for assisted housing programs increased from $5.72 billion in fiscal year 1981 to $13.6 billion in fiscal year 1990. Despite congressional efforts to increase Federal housing efforts, housing assistance meets only a small fraction of the housing needs of the low-income elderly.

The Housing and Community Development Act of 1987 (HCDA) made several important contributions concerning the elderly. These included: permanent authorization of the Congregate Housing Services Program (CHSP), which helps to enable frail and disabled individuals to continue to live independently; establishing the home equity conversion demonstration, and taking steps to address the crucial issue of loss of existing housing stock through the prepayment of mortgages for low-income housing, including the Section 202 program.

At the beginning of 1989, housing advocates had hopes that the new administration signaled the end of nearly a decade of massive cutbacks. Unfortunately, the housing news in 1989 was dominated by the unfolding of major scandals involving the Federal Department of Housing and Urban Development (HUD) and the impact of the Nation's drug crisis in public and other low-income housing.

The administration's fiscal year 1990 budget had proposed further cuts in the Section 202 program, from 10,000 units in fiscal year 1989 to 7,000 units in fiscal year 1990, and to reduce the proportion of units dedicated to the elderly. The administration's budget also had proposed to replace Section 202 direct loans with a new credit voucher program in which project sponsors would obtain financing from private sources for construction capital.

For fiscal year 1990, Congress rejected these administration proposals, but did make further cuts in the number of units to be funded in the Section 202 program (8,500 units). The administration argued that new construction of federally assisted housing was unnecessary, particularly during a time of intense pressure to reduce the Federal deficit, and that the problem is, instead, the affordability of existing housing stock. As a result, Section 202 is virtually the only new construction being funded, albeit on a greatly reduced basis, resulting in very long waiting lists in many communities.

Although the need for affordable housing and shelter assistance argues strongly for increased Federal efforts, resources, leadership, and fiscal concerns over the growing budget deficit continue to make Federal housing assistance targets for budget reductions and major program changes.

NAHA 1990 was signed into law on November 28, 1990. The Act authorized $27.5 billion in fiscal year 1991 and $29.9 billion in fiscal year 1992 to continue existing programs such as public housing, special housing programs for the elderly and handicapped, and rent subsidies, as well the creation of several new programs. This authorization level is approximately $3.3 billion more than FY 1991 spending levels. Over a 2-year period, as many as 360,000 additional units could be added to the federally assisted housing stock.

The cornerstone of the legislation is the HOME Investment Partnership Act. This provision establishes a block grant to localities and States under HUD's general supervision. The HOME program is a reaction to a widely held belief that HUD administration of housing assistance has been rigid and unresponsive to varying local markets and needs. Included in this provision is a set-aside for construction of affordable housing, but the majority of funds will be used to renovate existing housing projects.

The HOPE programs provide the opportunity for tenants to purchase subsidized housing of various types, including public housing. The HOPE programs, developed by the Bush administration, are criticized, however, by many housing advocates as providing a means to "sell off the limited public housing stock."

The HOME Investment Partnership Act and the HOPE programs, as well as all new programs created by the 1998 housing legislation, have yet to receive any appropriations. Although funds were authorized in the 1990 act, the HUD appropriation for fiscal year 1991 was enacted prior to the adoption of the National Affordable Housing Act. Existing programs, such as public housing and Section 8 assistance received funding, but no new programs were funded. In addition, it seemed unlikely that HUD would be able to write regulations and get the programs started before the new fiscal year ended, due to the complexity of the new legislation.

A number of programs, which combine social services with housing assistance to promote residents' rights and independence, were included in the new legislation. HOPE for Elderly Independence was established as a demonstration program to test the effectiveness of combining supportive services with housing assistance. Existing programs, such as CHSP, were reauthorized and refined to include numerous technical amendments. A major restructuring of the Section 202 program was included in the Housing Act as well. The Section 202 production program for the elderly was substantially revised to ensure that housing developed under the program be designed to accommodate the special physical and other needs of elderly persons. To achieve this, the Section 202(h) program for persons with disabilities will be fully separated from the elderly program. In addition, assistance in the form of capital advances and project rental assistance to nonprofit organizations may be used for construction, reconstruction, moderate or substantial rehabilitation, as well as others. The rental assistance will replace Section 8 assistance. These changes to the Section 202 program are authorized for implementation in fiscal year 1992.

Some longstanding housing problems were settled with the passage of the new housing legislation, in particular, the issue of prepayment. A major housing concern during the past several years has been the imminent threat of the loss of hundreds of thousands of units subsidized under the Section 221(d)(3) and 236 programs. Although these loans or mortgages have a term of 30 to 40 years, they contain a provision permitting owners to pay off the mortgage after 20 years, thereby ending Federal restrictions over the use of the property to benefit low- or moderate-income households. The new law requires HUD to offer incentives to owners to continue renting to low-income households, or to people to purchase the property and continue to provide such use. In very limited circumstances, owners will be able to prepay, but this will undoubtedly be the exception.

In response to the continued loss of funds by the Federal Housing Administration, the Act requires buyers to pay additional upfront costs when purchasing a home. The legislation also made some significant changes to the Section 8 voucher and certificate program. Oversight on the administration and effect of these programs and their funding remain as issues for the 102d Congress.

A. RENTAL ASSISTANCE PROGRAMS

Beginning in the 1930's with the low-rent public housing program, the Federal role in housing for low- and moderate-income households has expanded significantly. In 1949, Congress adopted a national housing policy calling for a decent home and suitable living environment for every American family. The Federal Government has developed a variety of tools and programs in an effort to achieve this goal. One approach has been to provide housing directly through rental assistance payments aimed at providing adequate and affordable housing for those who could not otherwise affort it.

Heightened concern over elderly related housing issues had its origin in 1950 when the first National Conference on Aging recommended greater Federal emphasis on the housing needs of older persons. It took almost 10 years, however, for legislation to be enacted that would eventually target the elderly as beneficiaries for such housing assistance.

Although low-income public housing created under the Housing Act of 1937 was not intended initially to provide special assistance for the elderly, it began to evolve into one of the principal forms of Federal assistance for low-income older persons in the late 1950's. Prior to 1956, persons 65 years and older occupied only 10 percent of all low-income public housing units. Between 1965 and 1959, however, several legislative changes were made to encourage construction of units for the elderly. As a result, the percentage of public housing units occupied by the elderly increased to 19 percent in 1964 and to 45 percent in 1988. In addition, the first housing program specifically designed for the elderly, the Section 202 program, was enacted in 1959.

In the mid-1970's, Congress significantly expanded Federal housing assistance to the elderly. The Section 202 elderly housing program was reinstated after being phased out in the late 1960's, and the Section 8 housing assistance program was enacted. Although not specifically targeted to the elderly, Section 8 has become one of the two major sources of assisted housing units occupied by those 65 years of age and older.

1. Supportive Housing for the Elderly

A major element of the recently passed NAHA 1990 addresses a problem that was not envisioned when housing policy was developed during the 1930's, the phenomenon referred to as "aging in place." As tenants of assisted housing grow older, they often become more frail and less independent. In time, many of these individuals, in the absence of various services, such as home-delivered meals and help with personal needs, are forced to leave their residences, typically to go into a nursing home. This problem has grown in significance over the past years, and the so-called "graying of America" ensures that it will become increasingly more important in the years to come. Title VIII of the new housing legislation, "Housing for Persons with Special Needs" stresses the need for supportive services to ensure independent living for the frail elderly. NAHA 1990 will help to provide a means for residents who with modest forms of supportive services or with appropriate modifications to their apartment, such as handrails or grab bars, can continue to live in their homes.

Since 1971, public housing authorities have had the authority to use Federal funds for the provision of dining facilities and equipment in public housing projects. No subsidy was to be provided to cover the cost of meals and other services. To date, there has been little development of these congregate facilities. This is due to a variety of reasons, including local housing agencies having had little experience in managing the necessary services, little Federal encouragement and support, and no assurance of funds to pay for the services on an ongoing basis. Most services have been provided by local service agencies funded by the Older Americans Act, Medicaid, and the Title XX Social Services Act.

Section 202 projects were not intended to be either intermediary care facilities or standard apartment rental units. Instead they were meant to provide shelter plus services appropriate to the needs of the elderly and handicapped. Although Section 202 projects for the elderly originally were designed to serve healthy older persons, survey results show that the majority of Section 202 tenants are "aging in place" and are now in need for supportive-type services. This is true, also, for many tenants of public housing. The results of a recent survey of the Nation's Section 202 sites conducted by the University of Illinois at Urbana-Champaign, with support by the AARP, and issued by the House Select Committee on Aging's Subcommittee on Housing and Consumer Interests, reveals that the average age of tenants in Section 202 projects for the elderly has increased to over 75. In the older section 202 projects, 35 percent of residents are over the age of 80. Survey results also indicate that in the older projects, over 15 percent of tenants are considered by project administrators to be frail. These figures are likely to increase over the next several years.

Although an average of six on-site services are offered per project, the types of services (such as personal care and housekeeping) that will enable the aging in place population to remain independent are offered on a very limited and fragmented basis. There is no Section 202 services model that applies to all projects in this program. As a result, project sponsors are free to interpret service needs however they choose.

In 1985, 28.5 million people (11.9 percent of the population) were 65 years of age or older. Of these, 1.3 million were living in nursing homes. Since the disabilities of nursing home residents vary from impairments in activities of daily living to severe handicaps, many of these people may be candidates for congregate housing. While there is no way of precisely estimating the number of elderly persons who need or prefer to live in congregate facilities, groups such as the Gerontological Society of America and the AARP have estimated that a large number of people over 65 and not living in institutions or nursing homes would choose to relocate to congregate housing if possible.

According to a 1989 report by the Urban Institute, "Providing Supportive Services To The Frail Elderly In Federally Assisted Housing," an estimated 105,000 residents of assisted housing who are age 65 and over require help in at least one activity of daily living; this is some 7 percent of the total over-65 population that reside in assisted housing. According to this same report, this number "is less than the one-third of elderly assisted housing residents who have some degree of frailty."

Viewed as one of the most crucial supportive services to help sustain independence for the frail elderly, meal programs became mandatory in 1987 for Section 202 units. In formulating these rules, HUD took into consideration a number of opposing arguments, and views the rule as a compromise between protecting residents' rights and independence as well as ensuring their nutrition, and protecting sponsors' housing-and-services ideal.

Many advocates for the elderly object to mandatory meals. They believe that forcing a resident to participate in a meal program when he or she could and would prefer to prepare his or her own food appears to be an infringment of individual rights and contradicts the support for elderly independence to which Section 202 sponsors are dedicated. Those in support of the program cite the fact that the adequate nutrition of elderly residents is a primary concern of Section 202 sponsors, arguing that many residents do not take the time, have the interest, or even remember to eat properly. Furthermore, as they age in place, residents increasingly are unable to prepare meals for themselves. Twice as many residents over 80 experience this difficulty, compared to those between 62 and 79.

Since funding for housing programs has been reduced dramatically in recent years, some States have established their own housing initiatives, including congregate housing programs, in an effort to provide their elderly citizens with needed care without relying on Federal funds. In the last few years, private developers have shown a growing interest in development of congregate housing. Congregate housing appears to be a viable alternative for housing the semi-independent elderly.

CHSP was originally authorized in 1978 as a demonstration program. The program was designed to help the elderly remain in rented dwellings as they age, rather than be institutionalized. During the demonstration, HUD extended multiyear grants (3–5 years) to eligible public housing agencies and nonprofit Section 202 sponsors for meals and other support services for frail elderly and nonelderly handicapped residents.

Throughout the Reagan years Congress kept the program alive, appropriating funds for the maintenance of existing CHSP sites. The HCDA made CHSP a permanent program, authorizing $10 million for each of fiscal years 1988 and 1989. The fiscal year 1989 appropriation for CHSP, however, was $5.4 million; for fiscal year 1990 it was $5.8 million; and for fiscal year 1991 it is $9.5 million. As of the end of fiscal year 1990, 60 grantees were in operation, serving approximately 1,920 residents. Although the fiscal year 1991 appropriation level represents a significant increase over previous years, it is less than half of the authorization level approved by Congress in the recently passed National Affordable Housing Act. Under NAHA 1990, the fiscal year 1991 authorization is $25 million and for fiscal year 1992, the authorization is $25.1 million. This reflects congressional effort to fund the necessary services to assist the elderly as they age in place, rather than addressing the consequences of the elderly being forced to reside in nursing homes without needing the full and costly level of support provided there.

NAHA includes a separate title devoted to "Housing For Persons With Special Needs." This provision will exclusively serve the elderly, persons with disabilities, homeless persons, or other persons "with special needs requiring supportive services related to their housing." According to the conference report (101–943), the purpose of the Section 202 program is to enable elderly persons to live with dignity and independence by expanding the supply of affordable housing designed to accommodate their special needs.

Under NAHA 1990, the revised congregate housing services program must be coordinated on-site and must provide meal services which meet at least one-third of the nutritional needs of the eligible residents. In addition to the meal program, other appropriate services include personal care, transportation, chore services, housekeeping, grooming, case management, nonmedical counseling, and medication assistance. The services provided must reflect the wants and needs of the elderly residents.

All of these reforms are under the jurisdiction of a newly created office of the Assistant Secretary for Supportive Housing. The Assistant Secretary for Supportive Housing is responsible for the administration of housing programs that serve the elderly, handicapped, or homeless. In addition, the Secretary will also serve as HUD's liaison with the HHS and other agencies on matters relating to supportive services for special tenant populations served by HUD housing programs.

In an attempt to promote independence among the housing residents, the recently passed legislation also requires each housing project that receives assistance under the congregate housing services program, to the maximum extent possible, to employ older and disabled adults who are residents to provide the services. These individuals will be paid wages no lower than the higher of the minimum wage under the Fair Labor Standards Act of 1938, the State or local minimum wage, or the prevailing wage rates for persons employed in similar public occupations.

As part of the Bush administration's major housing program, HOPE, a demonstration project to provide vouchers and certificates to enable low-income, frail elderly persons to help pay for needed supportive services is included in the new legislation. As part of this demonstration project, HOPE for Elderly Independence, the Secretary can also provide for services in connection with existing contracts for vouchers and certificates. During the 5-year demonstration, only 1,500 certificates and vouchers can be provided for housing assistance. Funding for the supportive services will be as follows: the Secretary would provide 40 percent, the public housing agency would ensure the provision of at least 50 percent, and each frail elderly person would pay 10 percent of the costs of the supportive services that he or she receives, except that no frail elderly person could be required to pay an amount that exceeds 20 percent of his or her income. If this 20-percent limitation results in the elderly person paying less than 10 percent of the cost of providing the services, the remaining costs would be divided equally between the Secretary and the public housing agency.

Although NAHA 1990 contains numerous measures pertaining to the provision of supportive services in federally assisted housing, none of the new programs, such as HOPE, received appropriations for fiscal year 1991. The increased funding level for existing programs, such as CHSP, however, is an encouraging sign that Federal housing assistance may be improving.

2. SECTION 202

The Section 202 program provides rental housing designed specifically for the elderly. In addition, it is the primary Federal financing vehicle for constructing subsidized rental housing for elderly and handicapped persons. NAHA 1990 includes a major restructuring of the Section 202 program for elderly and disabled persons. As previously stated, the purpose of the program is to enable elderly persons to live independently by expanding the supply of affordable housing designed to accommodate their special needs through the provision of supportive services.

The original Section 202 program operated from 1959 to 1969, when it was phased out in favor of other programs. During this 10-year period, the program provided construction financing and 50-year loans at 3-percent interest to nonprofit and limited-dividend sponsors of housing for low- and moderate-income elderly and handicapped persons. Approximately 45,000 units were constructed.

Under the revised Section 202 program authorized in 1974, loans to sponsors were made at a rate based on the average interest rate of all interest-bearing obligations of the United States forming a part of the public debt, plus an amount to cover administrative costs. The section 202 loan rate was capped at 9.25 percent in 1983, in response to rising interest rates; it was lowered to 8.38 percent in fiscal year 1990.

The original Section 202 program was successful. Only one project was foreclosed during the 10-year period. The program served mostly middle-income rather than low-income elderly. Since the revised program was used in conjunction with the Section 8 program (HUD's major vehicle for the provision of housing to low-income households), it served a wider range of elderly households.

Under the revised Section 202 program, funds were allocated on a geographic basis for metropolitan and nonmetropolitan areas among the 10 HUD regions, taking into account the number of elderly households within each region, those households lacking some or all plumbing facilities, and those with incomes below regionally adjusted poverty levels.

The Section 202 program is the most visible elderly housing program. Overall, it is considered one of the most successful of all assisted housing programs. Moreover, it now accounts for virtually all remaining federally assisted new construction for low-income Americans.

There are an average of six Section 202 units for every 1,000 elderly persons in the country. According to a December 1989 report by the Subcommittee on Housing and Consumer Interests of the House Select Committee on Aging, a national 1988 survey showed an average turnover rate of only 13.4 percent annually. Turnover rates are even lower in the oldest facilities, with the transfer to a nursing home or death among the more likely reason for turnover in these facilities.

As a result, there are lengthy waiting lists for Section 202 housing across the Nation. According to this same Housing Subcommittee report, only 8.2 percent of Section 202 facilities nationwide had no waiting list. In the Northeast, only 3.2 percent of facilities reported they had no waiting list. Furthermore, the survey found that in 1987, facilities in cities of more than 1 million reported that for every vacant unit there were 11 applicants. This ratio jumped to 28.5 applicants for every vacancy in those facilities most recently built. It is important to note that waiting lists represent only those who chose to apply—not those who were discouraged by the prospect of a long wait and therefore chose not to apply.

Indeed, the housing needs of several million elderly—housing that is affordable, safe, accessible, and suitable in terms of neighborhood amenities and services—have gone unaddressed. Program cuts have come not only at a time of current high demand, but also at a time when demand is expected to increase. The enormous projected growth of the elderly population suggests the prospect of rapidly increasing shelter and service needs that the Nation has just begun to recognize.

The Housing and Community Development Act of 1987 authorized $622 million in fiscal year 1988 and $630 million in fiscal year 1989 for loans under the Section 202 program. However, the fiscal year 1988 direct loan limitation for Section 202 was $565.8 million, which was intended to provide funding for the construction of approximately 10,990 new units. Further, the appropriations bill required that 25 percent of the loan authority under Section 202 must be used only for handicapped project loans, which represented an increase in the number of units built for the handicapped—and a decrease in the number of units built for the elderly. Ultimately, 25 percent of the funding for Section 202 in fiscal year 1989 went to handicapped housing. The fiscal year 1990 direct loan limitation for Section 202 housing was $472.6 million, with 25 percent targeted for exclusive use by the handicapped (2,375 units, with 950 units targeted for the deinstitutionalized mentally ill). This funded construction for approximately 8,500 new units for the elderly and disabled.

Because Section 202 is one of the few Federal housing programs under which new construction is taking place, it is likely that the program will continue to be the focus of attention from the various groups in need of housing. While most housing advocates agree that the elderly are but one of several segments of the population in need of safe and affordable housing, many feel it is tragic that those concerned about the housing needs of a particular segment of our population find themselves competing for scarce housing dollars.

At the close of 1989, the Secretary of HUD, in a report to Congress, responded to congressional pressure concerning cost containment efforts in the Section 202 program. The Secretary indicated that HUD was reviewing cost containment policies, including requirements governing efficiency units, common areas, and elevators. HUD maintained that the review would be completed in time to make changes effective for sponsors seeking fiscal year 1990 fund reservations.

A serious problem that has emerged over the past several years that led to congressional action in 1989 is the extraordinary backlog of approved (for financing and construction) Section 202 projects that have not yet been constructed. These approved projects are blocked in what is known as the construction "pipeline." The pipeline blockage has reached extraordinary proportions and threatens the financial viability of previously approved projects. Some suggest that the number of units in the pipeline may be as high as 50,000 units; HUD, in a congressionally mandated report, acknowledged that the "current Section 202 pipeline represents about 26,000 units." Even at the lower figure of 26,000 units, this amount takes on particular significance when considering the fact that the fiscal year 1990 appropriation was for 8,500 units, in fiscal year 1989 it was for 9,500 units, and for fiscal year 1988 the appropriations were for 10,990 units. The pipeline, at minimum, is equal to 90 percent of the total number of units approved by Congress for the past 3 fiscal years. To address the problem, a review of the current fair market rents (FMR) by HUD must be undertaken in order to find a more effective method to determine FMR in the future.

One of the most significant issues related to the provision of affordable housing relates to the use of FMR which HUD establishes for an area on the basis of rents tenants are willing to pay for housing. HUD has established 363 FMR areas. FMRs for a particular area play an important role in the ability of the project sponsors to provide quality housing for the elderly. Project rents cannot exceed 120 percent of the FMR established by HUD for an area. The income from project rents is used to pay for a project's operating and maintenance expenses and to amortize project financing costs (principle and interests). Consequently, by controlling the rental income which can be collected, FMRs serve to limit the mortgage financing or loans and, in turn, the projects' construction costs. HUD's policy uses rents to determine costs, rather than vice versa. This makes it difficult for Section 202 sponsors in areas with relatively low FMR's to provide housing consistent with higher FMR areas.

A 1987 study by Conroy & McIver supports these findings. It cites the arbitrary nature of FMRs, stating that "Fair Market Rents are neither fair nor market." How can the . . . rent be $376 in Augusta, Georgia and $502 in North Augusta, South Carolina when these two cities comprise one community . . .?"[1]

FMRs preclude the construction of some projects built in one area from being built in another because their cost would be too high. Again, these findings were corroborated by Conroy & McIver. The study compared the average construction costs for a typical Section 202 building in each FMR area with the construction costs "allowed" or supported by the FMR in each area (which are the costs upon which HUD bases its approval of projects). They found that in 66 of the 363 FMR areas, it would be almost impossible to build the typical project without significantly compromising underwriting criteria or without a significant contribution from the project sponsor or the locality. (Small sponsoring organizations are often unable to make contributions; if a locality is willing to make it, it often comes out of Community Development Block Grant (CDBG) funds.) Further, they found that there would be severe cost problems (shortfalls between $250,000 and $500,000) in 144 other areas.

Critics of the HUD construction requirements for cutting costs say that they are so stringent that some of the new buildings are too poorly constructed to last the 40-year term of the mortgages. Therefore, amenities like meeting halls and recreational areas, which draw the elderly into a community, are being sacrificed. There is general support for cost containment in that maximizing the number of units built enables the program to serve more people. However, because many of the cost containment policies result in either inadequate housing or discourage the development of new housing, critics believe they are misguided at best. Many housing advocacy groups support reevaluation and possible elimination of many of these policies, FMR's among them.

NAHA 1990 responds to many of the concerns over past housing policy strategies in the Section 202 program. Most notably, the Section 202 program was revised to ensure that housing developed under the program would be designed to accommodate the special physical and other needs of elderly persons. To achieve this, the Section 202(h) program for persons with disabilities would be fully separated from the elderly program.

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[1] Letter from Diana L. McIver of Conroy & McIver, to Thomas Demery, Assistant Secretary for Housing, U.S. Department of Housing and Urban Development, Washington, D.C., April 27, 1987.

As of fiscal year 1992, the means of financing Section 202 housing for the elderly is changed to a direct grant and provision of operating assistance in place of the current loan and Section 8 methods of subsidy. The provision of supportive serivces, including those needed by the frail elderly, is required. Services to nonresidents are permissible if it would not adversely affect the cost effectiveness or the operation of the project. In addition, a provision was made for retrofitting already existing structures for the frail elderly.

Other changes to Section 202 include the establishment of tenant rents as the highest of the following amounts: 30 percent of a person's adjusted income, 10 percent of a person's monthly income, or the shelter rent payment as determined by welfare assistance if the person receives such assistance. The revised congregate housing services program contains a number of substantive and technical changes, as discussed in the previous section.

The Section 202 program has undergone numerous changes since its inception in 1959, including the most recent separation of the elderly and disabled programs. The changes to the financing of the program are reflected in the fiscal year 1991 appropriation levels. Capital advances for Section 202 received appropriations of $610.1 million for fiscal year 1991, and rental assistance received $449.6 million. Despite the criticism of the program, it continues to receive funding and support from Congress, which enables Section 202 to provide decent, safe, and sanitary housing for the elderly.

3. Public Housing

Conceived during the Great Depression as a means of aiding the ailing construction industry and providing decent, low-rent housing for the families of unemployed blue-collar workers, the Nation's Public Housing Program has burgeoned into a system that includes 1.4 million units, housing more than 3.5 million people. In fiscal year 1991, $5.7 billion for public housing was appropriated for operating subsidies, construction debts, and major repairs.

The Low-Rent Public Housing Program is the oldest of those Federal programs providing housing for the elderly. Approximately 45 percent of the Nation's public housing units are occupied by older Americans. It is a federally financed program operated by locally established, nonprofit Public Housing Authorities (PHAs). Each PHA usually owns its own projects. By law, the PHAs can acquire or lease any real property appropriate for low-income housing. They also are authorized to issue notes and bonds to finance the acquisition, construction, and improvement of projects.

Until recently, Federal assistance to public housing projects was in the form of annual contributions used to defray the PHAs' debt. Beginning in fiscal year 1987, funding for development and modernization was provided through capital grants, rather than financing of long-term debt. Originally, funding of capital costs was the only form of Federal public housing assistance. It was assumed that tenants' rents would cover project operating costs for such items as management, maintenance, and utilities. Rents were originally set for each apartment regardless of income, then limited to 25 percent of net income, and are now 30 percent of net income.

Tenant rents, however, have not kept pace with increased operating expenses.

Changes requiring greater targeting of benefits to the very low-income group, 50 percent of area median, have also decreased rental revenues for public housing authorities. As a result, beginning in 1969, Congress provided additional assistance to the projects to cover these expenses. Operating subsidies totaled $1.79 billion in fiscal year 1990. The National Affordable Housing Act authorized $2 billion for operating subsidies in 1991 and $2.086 billion in 1992. The appropriation level for fiscal year 1991 is equal to its authorization.

About one-half of the units in the Nation's 10,000 public housing projects are more than 20 years old, and many were built in the 1930's and 1940's. Much of the public housing stock is in need of major renovation, but the amount of funds needed to restore these units to a safe and inhabitable condition has been a topic of much debate. A congressionally mandated study by Abt Associates released by HUD in April 1988, estimated the figure at approximately $21.5 billion. HUD disagreed with that, stating that the cost should be $9.2 billion, less than one-half the amount estimated by Abt Associates. Among the funds HUD considers excessive in the Abt Associates' estimate are $5.7 billion for repairs it claims are not essential, $1.4 billion for energy conservation efforts, and money allocated for the 73,000 units (and possibly as many as 168,000) that will be demolished or sold. HUD's figure has been criticized by public housing supporters as grossly inadequate; a minimum of $18 billion was determined necessary by engineers and architects contributing to the Abt study.

About half of all the units in federally assisted housing were developed under and continue to be operated within the Public Housing Program. It has been by far the largest program for the production of housing for low-income families. In recent years, substantial dissatisfaction with the program has been voiced from several quarters, including Congress, about the condition of the projects and their management; from PHAs about their rising costs and the inadequate funding levels for operation and modernization; and from the OMB about ever-burgeoning outlays.

Even its staunchest supporters admit that the program has been plagued by mismanagement in some cities. Recognizing the need for better managerial oversight, Congress included in NAHA 1990, a number of performance indicators for public housing agencies. Under the new law, HUD must develop and publish standards to be used to assess the management performance of public housing agencies in all major areas of management operations, including the number and percentage of vacancies, the amount of funds obligated to the PHA which remain unexpended after 3 years, outstanding maintenance work orders, and units not inspected for maintenance or modernization needs.

Another critical problem in public housing is the lack of congregate services for tenants who have "aged in place" and need supportive services to continue living independently. A 1986 study on aging in place in public housing projects found that the elderly in public housing are more likely than other elderly to live alone, and that 15 percent of the elderly households had at least one disabled member.[2] About 70 percent of these households had annual incomes between $3,000 and $6,000; only about 25 percent had incomes over $6,000; with only 5 percent with incomes over $10,000. These households are heavily dependent on Social Security, and to a lesser extent, Supplemental Security Income (SSI). Only 10 to 15 percent had either wage or private pension income.

About 30 percent of PHAs will retain residents who have some supportive service needs; 10 percent require complete independence, and the rest will retain residents if they or others can arrange for the necessary services. About one-half of the elderly developments and 20 percent of the family developments reported operating under formal policies regarding the retention of residents. Of the 100 large PHAs surveyed (and a total of 204,800 elderly households), about 48 percent lived in units built for the elderly and handicapped, 15 percent lived in units built for the elderly but in mixed family/elderly developments, and 37 percent live in unmodified family units in family developments.

About 50 percent of the PHAs surveyed did not regularly collect any information about their elderly residents' functional levels, medical histories, or service use or needs. PHAs provide some services directly or through contracts with provider agencies in about half of all elderly developments and about 30 percent of all family developments. Only about 40 percent of the developments have onsite tenant services staff provided by the PHA; 20 percent of the PHAs report that no services or referrals are available except on an emergency basis in elderly developments. While a high proportion of developments have some services available that are used by some residents, there is evidence that these services may often only reach a few residents, leaving a large unmet need.

Under NAHA 1990 Congress established service coordinators as eligible costs for operating subsidies. In addition, up to 15 percent of the cost of providing services to the frail elderly in public housing is an eligible operating subsidy expense. Services may include meal services, housekeeping and chore assistance, personal care, laundry assistance, transportation, and health-related services. Although this is an eligible cost, it is not required and therefore does not have a separate authorization.

4. SECTION 8

The Section 8 rental assistance program was created in 1974 to provide subsidized housing to families with incomes too low to obtain decent housing in the private market. Under this program, subsidies were paid to landlords on behalf of eligible tenants not only to assist tenants paying rents in existing housing, but also to promote new construction and substantial rehabilitation. Section 8, however, came to be seen as excessively costly, particularly those units attached to new construction and rehabilitation. As a result, authority to enter into new contracts for assistance to new or substantially rehabilitated units was eliminated in 1983.

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[2] William L. Holshouser, Jr., *Aging in Place: The Demographic and Service Needs of Elders in Urban Public Housing* (Boston, MA: Citizens Housing and Planning Association), 1986, p. 185.

The concern over the Federal deficit has forced the Federal Government to reassess the cost-effectiveness of many housing-related programs, including the new housing construction programs. Section 8 was not designed originally to provide any form of direct subsidy to project sponsors in meeting their costs of construction and financing, but was structured to stimulate construction by guaranteeing that low-income occupants would be subsidized through rental assistance programs, thereby assuring occupancy—and rental income—for the developed units.

Shortly after the start of the program, developers found they had difficulty in keeping their rents below those established by HUD's fair market rents, largely because of the high mortgage rates prevailing in the late 1970's. Consequently, effective rates were lowered for most projects, either by the Government National Mortgage Association's (Ginnie Mae) purchase of mortgages under its special function, or by financing from State housing financing agencies or from public housing agencies, both of which obtained funds from sale of tax-exempt bonds. Ginnie Mae exhausted its available funds, and it became evident in 1981 that increased rates in the tax-exempt market were threatening to halt assisted housing production. By the end of 1982, limited additional assistance had been provided to projects financed through State housing finance agencies by means of the finance adjustment factors which, in effect, raised permissible rents over the fair market rent level. The relatively high subsidy cost raising from both the high rent supplement required to cover construction costs and the additional indirect subsidy to lower interest rates caused increasing concern in the administration and Congress. Finally, in the Housing Act of 1983, the Section 8 new construction program was repealed except for that attached to the Section 202 program.

While the production component of the Section 8 program has been viewed as unsuccessful, the existing housing component of the Section 8 program generally has been alluded to as a successful form of assistance. Under the Section 8 existing housing program, HUD pays the difference between 30 percent of an assisted-housing tenant's income and the fair market rent standard for the jurisdiction, with some exceptions permitting up to 120 percent of the fair market value.

Data on the characteristics of assisted families, market areas in which the program operates, units assisted, and other information necessary for evaluation of the success of or difficulties in the Section 8 program have been extremely difficult or impossible to obtain from HUD records as they are currently maintained. Under the new housing legislation, NAHA 1990, HUD is now required to maintain such information in an automated system. In addition, the findings from these data must be reported with recommendations for any appropriate legislative or administrative actions.

For fiscal year 1991 appropriations, the program received $1.07 billion for an estimated 33.5 thousand Section 8 certificates and $811 million for an estimated 27.9 thousand vouchers in appropriations for 1991.

5. SECTION 8 CERTIFICATES AND VOUCHERS

Traditional public housing assistance to low-income families offers few choices as far as the location and type of housing units desired. As an alternative to this problem, the Reagan administration strongly pushed for a system under which low-income families received vouchers similar to food stamps. The Bush administration is continuing this effort. Vouchers are intended to enable a family to rent housing in the private market, assisted by a Federal payment transmitted through a local public housing agency (PHA) to a landlord.

The Housing Act of 1983 continued existing Section 8 certificates, but also established a Section 8(o) voucher demonstration program. Use of the 15,000 vouchers authorized by the act was limited primarily to HUD's Rental Rehabilitation and Development Program. However, 5,000 units were allocated to a free-standing program to provide an opportunity to compare the operation of the voucher program with the existing Section 8 certificate program.

Vouchers subsidize the difference between 30 percent of the family's income and a rent standard, equivalent to the fair market rent (FMR). The actual rent, however, is negotiated by the tenant and landlord, as in the private market; it may be higher or lower than the rent standard, and the tenant pays the difference between the HUD payment and the contract rent, which can be either more or less than 30 percent of income. The Section 8 certificate, however, limits the tenant's rent payment to 30 percent of income, and the maximum contract rent to the HUD-determined FMR.

The tenant, however, likely will pay more or less than 30 percent of his or her income for rent. Under the vouchers, HUD's contribution is still based on a 30-percent-of-income contribution, but the rent standard is not necessarily the actual, or maximum, rent. Rather, the rent received by the landlord is based on whatever is negotiated between the tenant and landlord, as in the private market. Thus, if a tenant finds a unit that is cheaper than HUD's rent standard, that tenant would be able to keep some of the subsidy for other uses. Conversely, if a tenant rents a unit that is more costly than the rent standard HUD uses, the tenant would have to contribute more than 30 percent of income to make up the rent payment.

Advocates of the voucher program argue that, like the Section 8 certificate programs, the voucher system would avoid the segregation and warehousing of the poor in housing projects and would allow low-income families to choose where they live—all at less cost than new construction programs. Moreover, since the contract is for 5 years rather than 15, less budget authority need be appropriated in any 1 year for the same number of assisted families. Recipients of Section 8 certificates do not have this option. However, the 1989 HUD appropriations bill reduced the contract term for Section 8 certificates to 5 years, in an effort to place the vouchers and existing certificate units on the same basis.

Shifting to voucher assistance presents potential problems for the elderly in need of housing assistance. It is important that vouchers not be looked to as a replacement for new construction of housing for the elderly that is built to accommodate their special needs, such as accommodation for wheelchairs and grab rails in bathrooms, in the private market.

The voucher system has been met with skepticism by Congress and many housing advocates. Critics of the program point to a shortage of decent low-cost housing in the largest cities. They question whether vouchers will provide real help to those most in need or simply encourage private landlords to increase rents because they know tenants have additional funds available. Critics raise the point that since the vouchers are only authorized for 5 years, they do not represent a commitment to providing housing for the poor. They believe the budget savings are illusory, since the need will continue and, presumably, additional funds will be appropriated to continue assistance at the end of the 5-year period.

There is also concern that vouchers are costing more than Section 8 certificates, which has been exacerbated by HUD's failure to adjust FMR's to reflect changing market conditions. HUD should explore methods of setting the FMR to more accurately reflect shifts in local housing markets as a means of reducing the inequities arising between voucher holders and certificate holders in various parts of the country.

NAHA 1990 modified both the certificate and voucher programs to accommodate some of these positions. In the certificate program, tenants may pay more than 30 percent of income for rent for units renting above the FMR, if the PHA finds both the rent for the unit and the rental payment for the family are reasonable. It may not approve such excess payments for more than 10 percent of its incremental allotments in any 1 year. A report must be filed with HUD if the PHA approves more than 5 percent. In the voucher program, the PHA is required to determine for all new leases or lease renewals that the rent charged is reasonable in comparison with rents in comparable unassisted units or those assisted with certificates. If the rent is determined to be unreasonable, the PHA may disapprove the lease.

In addition, under the new legislation, voucher assistance is now available to lower income families who utilize a manufactured home as their principal place of residence. Assistance may be used for the rental of real property on which the manufactured home owned by the family is located. The voucher may also be used to rent the manufactured home and the real property on which it is located.

In response to the controversy over the fair market rent calculation, Congress required GAO to conduct case studies to examine and report on the geographic dispersion of certificates and vouchers in market areas. The report must also address how FMR levels may inflate rents. The Housing Act also authorized HUD, upon request of a PHA, to approve separate fair market rents for "submarket" areas within a market area if the alternative FMR proposed accurately reflects rent variations between such areas and the established market area.

The conference report on NAHA 1990 contains authorizations for Section 8 certificates/vouchers of $1.88 billion for fiscal year 1991 and $1.96 billion for fiscal year 1992, of which not more than 50 percent may be utilized for voucher assistance. The HUD appropriations legislation included $1.07 billion for Section 8 certificates and $811.9 million for vouchers. In addition, $7.7 billion will be used for expiring certificates.

6. THE FARMERS HOME ADMINISTRATION

The Housing Act of 1949 authorized the Farmers Home Administration (FmHA), administered by the Department of Agriculture, to make loans and grants to farm owners to construct or repair farm dwellings and other buildings. Amendments to the Act made the programs available to rural residents, in general, to purchase or repair homes and for other purposes. The rural housing programs of FmHA are generally referred to by the section number under which they were authorized in the Housing Act of 1949 and its subsequent amendments.

Section 502 loans enable low-income rural residents to purchase or repair new or existing single-family housing. Borrowers may receive interest credit to reduce the interest rate to as low as 1 percent. The loans are repayable over a 33-year period. The loan term may be 38 years for borrowers with income below 60 percent of the area median. The borrowers must be unable to obtain credit elsewhere on reasonable terms.

Section 504 loans are made to rural homeowners who could not afford a Section 502 loan but need funds to make the dwellings safe and sanitary or to remove health hazards. Very-low income elderly homeowners may qualify for grants or some combination of loans and grants.

With Section 514 loans, farmers or organizations may obtain 33-year loans to provide "modest" living quarters and related facilities for domestic farm laborers. Qualified nonprofit organizations, Indian tribes, and public bodies may obtain Section 516 grants for up to 90 percent of the development cost of such housing.

Under Section 515, by far the largest and most important FmHA program serving the elderly, developers may obtain 50-year, 1 percent loans to build rental housing for rural residents or congregate housing for the elderly and handicapped. Except for public bodies, all borrowers must demonstrate that financial assistance from other sources will not enable the borrower to provide the housing at terms that are affordable to the target population.

Section 521 provides for rental assistance payments to borrowers to make up the difference between the tenants' payments and the FmHA-approved rents for the housing (financed under Section 514 or Section 515). Borrowers must agree to operate the property on a limited profit or nonprofit basis.

Section 533 preservation grants authorized FmHA to make grants to organizations for rehabilitating rural single-family homes, rental properties, and cooperative housing.

Housing problems in rural America continue to be severe, particularly for those with low incomes. A 1989 report, "The Other Housing Crisis: Sheltering The Poor In Rural America," by the Center on Budget and Policy Priorities and the Housing Assistance Council, maintains that "some 27 percent of nonmetro[politan] elderly households were poor in 1985, compared with 19 percent of the elderly in metro areas." The report indicates that of these poor households, nearly 70 percent are those who live alone, and of these, most are women.

The administration's budget for fiscal year 1990 (the Bush administration's first year) would have terminated most existing FmHA rural housing programs. Congress, however, rejected this and funded FmHA programs for fiscal year 1990, providing $1.32 billion for low-income, single-family loans (Section 502), and $580 million for rural rental housing loans (Section 515). The rural housing repair loans program (Section 504) is provided with $11.3 million, and farm labor housing loans (Section 514) are provided with $11.5 million.

Housing assistance under FmHA received a total of $2.34 billion in appropriations for fiscal year 1991. Specifically, Section 502 received $1.22 billion, Section 504 received $11.3 million for loan assistance and $12.5 million for grants, Section 514 was appropriated $16.3 million, and Section 515 received $573.9 million for 1991. In addition, the Act provides the Secretary of the Department of Agriculture with aggregate loan insurance and loan authority of $2.13 billion for fiscal year 1991 and $2.22 for fiscal year 1992.

NAHA 1990 established a 2-year demonstration program for deferred mortgage payments. Under this program, the Secretary is permitted to defer Section 502 loan payments for families who do not have sufficient income to repay Section 502 loans, but who would otherwise qualify under Section 502. FmHA can defer up to 25 percent of Section 502 mortgage payments at 1 percent interest for very low-income families or persons otherwise deemed unable to afford the regular payment. The deferred mortgages would return to normal payment status when the borrower's ability to repay improves and deferred amounts are subject to recapture. Subject to appropriations, no more than 10 percent of the amount approved for Section 502 loans may be authorized for use in this demonstration program.

Under Section 515, the Housing Act contains a provision which reserves 7 percent in fiscal year 1991 and 9 percent in fiscal year 1992 of Section 515 funds for nonprofit sponsors. Nonprofit sponsors are those organizations which are exempt from Federal taxes under section 501(c)(3) and section 501(c)(4) of the Internal Revenue Code, and whose principle purposes include the planning, development, and management of low-income housing. This set-aside will make it possible for those with minimal resources, but with the ability to plan and carry out an eligible project, to receive assistance.

7. PROGNOSIS

For advocates of a strong Federal role in meeting the housing needs of the Nation's low-income citizens, the passage of NAHA 1990 renewed optimism that the downward decline of the Federal role during most of the past decade would be reversed in the near future.

NAHA is a sweeping package of initiatives that address major facets of America's housing needs. The legislation includes rental assistance provisions to: tackle the affordability of rental housing, combine the best features of section 8 certificates and vouchers;

revise the Section 202 program; and increases incentives for loan eligibility under the Farmer's Home Administration for low-income households.

Of particular significance to the elderly is the new title, "Housing for Persons with Special Needs," to specifically address the needs of the elderly, persons with disabilities, and the homeless. For the elderly, the Section 202 program would continue with a new funding system that requires much less budget authority per unit, and the manner in which tenant rents are computed would be changed, which should help to ameliorate the "pipeline" problem. Elderly housing would be designed to: meet the special physical needs of the elderly, including those who are frail; and accommodate supportive services needed by these individuals. A "Project Retrofit" would upgrade existing elderly housing, making new forms of HUD assistance available only when a project receives assurance that long-term funding for supportive services will be provided by State, local, or other sources. The administration's HOPE initiative would also address the supportive services needs of the frail elderly, although on a much more limited basis. A demonstration program would be established that would link vouchers with other assistance to help the frail elderly to pay for needed services.

Although the new housing legislation authorized a number of new programs, appropriations for fiscal year 1991 were authorized only for existing housing programs. HUD may adopt expedited procedures for at least some of the programs by requesting a supplemental appropriation. The request could be for additional funds; however, there is fear among some housing analysts that HUD will instead request funds from existing programs, such as public housing or modernization, to the new programs. Aside from funding, HUD now faces the enormous task of developing regulations for these programs, overseeing their operation, and evaluating their efficiency.

B. HOMEOWNERSHIP

Rapidly escalating housing costs have contributed to the growing need for Federal support. This problem is expected to continue as the number of older Americans increases and the cost of housing rises in relation to other living expenses. Housing costs for the elderly are being driven up by taxes, rising utility bills, high home repair costs, and insurance, as well as rent hikes and condominium conversions. The result is a serious lack of affordable and safe shelter for a large number of older Americans, especially for the low-income.

Homeownership rates have been declining since 1980, after rising steadily since the 1940's. Assistance to homeowners takes a myriad of forms, including tax reductions, Federal underwriting of mortgage markets, and the use of tax-exempt revenue bonds by local governments for first-time buyers. The pattern of homeownership has been consistent to many years; the older the members of a household, the more likely they are to reside in owned housing.

Approximately 75 percent of the age 65 and older population own their homes. The cost of maintaining these homes, however, is often a heavy burden, due to the large portion of older homeowners with relatively low incomes. Their homes are often their only asset. NAHA 1990 responded to this problem by increasing the number of available home equity conversion mortgages tenfold, to 25,000. In addition, the new legislation contains numerous provisions relating to rural, public housing and the special needs of the elderly and homeless.

1. Home Equity Conversion

Homes are older Americans' most commonly held and most valuable assets. Three out of every four elderly persons own their homes and recent statistics indicate that 80 percent of these do not have a mortgage. Equally significant, a large portion of older homeowners are likely to have relatively low incomes. For example, 6 out of every 10 elderly, single homeowners have incomes of $5,000 or less.

Estimates of the amount of equity tied up in the houses of persons over the age of 65 have ranged from $700 billion to $1 trillion. Thus, a great deal of attention has been paid in recent years to financial arrangements that would permit aged homeowners to convert part of their equity into cash, without having to leave their dwellings. These home equity conversion (HEC) plans offer a choice to elderly persons facing necessity-heavy budgets that have grown proportionately faster than their incomes. HEC plans also could provide funds to allow older persons to pay for needed supportive services, home maintenance, and other needs. Before HECs, the only source of equity borrowing available to older Americans was through the traditional financial institutions at high rates and short terms.

There are two distinct types of conversion plans, debt and equity, on which a variety of models are based. Debt plans allow an older homeowner to borrow against home equity with no repayment of principle or interest due until the end of a specified term of years, or until the borrower sells the home or dies. These plans can provide a single lump-sum payout to the borrowers, a stream of monthly payouts for a given term or—with the addition of a deferred life annuity—guaranteed monthly payout for life. They are often referred to as reverse mortgages or reverse annuity mortgages.

Property tax deferral programs, popular in many States, are a form of debt plan in which older homeowners postpone paying their taxes until they sell their homes or die. In State-initiated deferral programs, the State pays taxes to the local government for the homeowner. These payments accrue with interest as a loan from the State to the homeowner, secured by equity in the home. Upon death or prior sale of the home, the loan is repaid to the State from the proceeds of the sale of the estate.

Equity plans involve sale of the home to an investor, who immediately leases it back to the seller. Land contract payments of the seller exceed term payments to the buyer, so the older person receives extra cash each month. In addition, the buyer pays the taxes, insurance, and maintenance. A deferred annuity or other investment purchased with the down payment can provide income beyond the land contract term. In light of recent tax reform efforts, these plans, referred to as sale/leasebacks, have been virtually eliminated.

The basic theoretical forms of HEC plans have been established for several years. In general, however, workable instruments have yet to become widely available to the public. One reason for the lack of substantial interest is that the combination of financial benefits and risks associated with the plans have not been sufficiently attractive to borrowers. Moreover, lenders have also been reluctant to accept the risks associated with HEC programs.

The Housing and Community Development Act of 1987 (HCDA) created a demonstration program to provide mortgage insurance for home equity conversion mortgages for the elderly. Under the demonstration, the FHA insures the mortgages and provides protections for both lenders and homeowners from the risks. The demonstration originally provided that a total of 2,500 mortgages could be insured by participating lenders through September 30, 1991.

The National Affordable Housing Act of 1990 amended this provision to extend the reverse mortgage program until September 30, 1994. In addition, the new legislation requires disclosure of the extent of the liability of the homeowner under the mortgage and the projected total future loan balances for at least two projected loan terms. This provision increases the number of mortgages insured under this program to no more than 25,000. The mortgages are available to homeowners age 62 and older with little or no mortgage debt remaining on their homes. Rules issued by HUD to implement the program allow for the offering of three types of home equity conversion mortgages: (1) tenure; (2) term; and (3) line of credit.

Tenure mortgages provide for monthly payments from lenders to homeowners for as long as they occupy the home as a principal residence. Term mortgages provide for monthly payments for a fixed period agreed upon between the lender and the borrower. Line of credit mortgages permit homeowners to draw money at times and in amounts of their own choosing. Under this demonstration program, the interest rate on the loans may be fixed or variable. However, effectively only variable rates are now being offered under the FHA demonstration.

Homeowners retain ownership of their property and may sell and move at any time, retaining the sales proceeds in excess of the amount needed to pay off their mortgage. They cannot be forced to sell their homes to pay off their mortgage, even if the mortgage principal balance grows to exceed the value of their property. When the mortgage does come due, the lender's recovery from the borrower will be limited to the value of the home. There will be no deficiency judgment against the borrower or the estate.

HEC plan advocates of reverse mortgages stress that it is important that individuals and organizations maintain some perspective as they are developing plans to enable the elderly to convert their home equity into a form of income. The development of options for home equity conversion plans should be seen as a service that is provided to elderly homeowners and not as a product to be marketed. This is a portion of the population for whom financial mistakes may be devastating.

2. HOPE—Homeownership and Opportunity for People Everywhere

The HOPE program is the major housing program of the Bush administration incorporated into NAHA 1990. HOPE programs provide the opportunity for tenants to purchase housing of various types, including public housing projects. There are three types of housing available under the HOPE programs. HOPE I addresses the sale of public housing to its occupants. Under HOPE II, resident or other low-income families may purchase multifamily properties owned or held by HUD or other Federal agencies or State or local governments, financed with a HUD-insured or HUD-held mortgage. HOPE III provides for grants to encourage the sale of publicly owned single-family properties to low-income families, who are not homeowners and who could not otherwise afford to buy a home.

With respect to the public housing, it in effect continues the program first established in 1987 under which resident management corporations had the right to purchase projects for resale to tenants. Parkside-Kenilworth in Washington, DC, is the only project which had successfully taken advantage of the 1987 program, which has now expired. Under HOPE I, both the planning and implementation grants are authorized on a competitive basis to applicants from jurisdictions which have to develop and carry out plans for this purpose.

The grant applications must include not only specification of the activities for which the facility will be used, but also certification by the person responsible for the strategy's submission that the activities are consistent with the comprehensive housing affordability strategy of the appropriate jurisdiction.

The implementation grants may be used for acquisition and rehabilitation costs, counseling and training of homebuyers, and the relocation of tenants not wishing to purchase. In addition, the operating expenses and reserves may be acquired through the grants provided that the amount is not greater than would have been received for operating assistance if the project had continued to receive a public housing operating subsidy. The grant may also be used for economic development activities promoting "self-sufficiency" of the residents and homebuyers. Applicants must provide 25 percent matching funds, except for funds used for post-sale operating expenses, from non-Federal sources. Non-Federal sources do not include Federal tax expenditures or Community Development Block Grants (CDBG), except that CDBG funds may be used to match expenditures for administrative expenses.

NAHA 1990 specifies the requirements for grant applications, the criteria to be used in selecting grant recipients, and the requirements to be met for the sale of housing to individual tenants or a cooperative association. The rights of tenants not wishing to purchase are outlined, including the provision of Section 8 assistance for those wishing to move. Critics of HOPE view the program as a means of selling off the Nation's limited public housing stock. As a means of keeping at least the existing public housing supply, the HOPE program includes a provision that prohibits the sale of public housing unless the Secretary has entered into an agreement with the local public housing agency to replace each unit of public housing with additional affordable housing. These replacement units may include newly constructed public housing projects, the rehabilitation of vacant public housing units, and the use of 5-year, tenant-based rental assistance vouchers. The latter, however, offers only a temporary solution, and many feel these "displaced" individuals could add to the already increasing number of homeless.

Restrictions are established on the rights of resale for purchasing tenants. After sale of a project by the PHA payments under annual contribution contracts for the original development costs are required to continue, but public housing operating subsidies are to end. Any funds obtained from the sale to families or other approval entities are to be used for costs of the homeownership program, which include physical improvements, operating expenses, or economic development programs.

The HOPE programs grew out of a Bush administration belief, shared by many community organizations, that homeownership gives low-income families a stake in society which boosts their morale and provides a basis for improving their skills and employability. The rationale for the HOPE programs is based on the belief that homeownership "empowers" the individual. Many questions, however, have been raised as to the validity of this belief. Even with the subsidies provided by the HOPE program, many low-income tenants will not be able to afford to purchase. The debate in Congress continued throughout the passage of NAHA 1990 over spending large sums of money and HUD staff attention for the purpose of homeownership as opposed to the extension of and improvements in the federally assisted rental programs.

Congress authorized HOPE I $68 million in fiscal year 1991 and $380 million in fiscal year 1992 to be appropriated. Homeownership of multifamily units, HOPE II, was authorized at $51 million in fiscal year 1991 and $280 million in fiscal year 1992. HOPE III, homeownership of single-family homes, received an authorization level of $36 million in fiscal year 1991 and $195 million in fiscal year 1992.

3. PROGNOSIS

Homeownership is considered by many to be part of "the American dream," and government housing policies have consistently contained elements designed to encourage or assist it. Because home purchases nearly always require mortgage financing, most government aid has been aimed at assuring financing or alleviating the burden of it.

The National Affordable Housing Act of 1990 contains a number of provisions to assist in homeownership. It allows first-time buyers to use IRAs or 401(k) retirement plans for home investments; it sets FHA mortgage ceiling at 95 percent of area median sales prices without regard to national dollar ceiling; and it extends mortgage revenue bonds and mortgage credit certificate programs through 1992. The administration's HOPE initiative addresses various major housing issues through such proposals as providing opportunities for low-income tenants or federally assisted housing to purchase properties when owners decide to opt out of the Federal programs, and extending low-income tax credits to the private sector for construction and rehabilitation of low-income housing.

Although reductions in direct Federal spending on housing programs can be expected to result in some amount of replacement spending by the private sector, it is evident that it will not supplant the Federal role in meeting the needs of low- and moderate-income households and neighborhoods. The necessity for Federal leadership and resources is evident to virtually all concerned about housing.

Homeowners came through the 1986 tax reforms essentially unscathed (see Sec. C2 of this chapter). They retain the right to deduct mortgage interest and property taxes against income for tax purposes. The law continues to disregard the implicit income an owner receives from occupying a potentially rentable property. The benefits are worthless, however, at the lower average rates of the 1986 act.

In the aggregate, homeowner deductions of mortgage interest and property taxes and other preferences entail 1991 revenue losses to the Treasury of approximately $55 billion. Critics note that the tax benefits to homeowners are regressive, awarding larger deductions to high-income owners than to less affluent ones. No comparable tax advantages are offered to renters, a group with much lower average income than homeowners. Some economists also argue that these preferential tax provisions not only contribute to overconsumption of housing by the well-to-do, but also tend to push up home prices. These observers hold that the considerations of revenue costs, economic efficiency, and equity suggest a fresh look at the tax treatment of owner-occupied housing.

C. PRESERVATION OF AFFORDABLE HOUSING

Since its inception, housing policy in America has focused almost exclusively on the provision of standard units of low- and moderate-income housing for eligible individuals and families. This approach has been inadequate in that the Federal Government has been unwilling to treat housing assistance as an entitlement. As a result, many eligible households simply cannot find the assistance they need. Data indicates that the more than 4 million assisted units available at the end of fiscal year 1985 are enough for, at best, 25 percent of those eligible for assistance. Further, while there were 16 million elderly households in 1980, this number is projected to increase to 23 million in the year 2000. This means that the elderly will need 7 million more units in 2000 than they had in 1980—assuming that all elderly households in 1980 were decently housed and that the present housing stock will be maintained.

According to a 1986 report of the National Low Income Housing Coalition, Federal housing efforts have fallen far short of meeting elderly housing needs. In 1984, there were 1.1 million elderly renter households with income below the poverty level. Only 444,000, or not quite 40 percent, of these households lived in subsidized housing. The remainder lived either in substandard housing or paid more for housing than they could afford, or both. The Coalition estimates that, at a minimum, almost 700,000 poor elderly need housing assistance. In addition, there are 1.5 million elderly homeowners with incomes below the poverty level.

A 1988 study by the National Low Income Housing Preservation Commission found that as a result of expiring Federal housing support programs and the effects of the 1986 tax reform act, defaults and prepayments could remove as much as 81 percent of the stock from the inventory of low-income housing. If no action is taken, 523,000 of the 645,000 units subsidized under Sections 221(d)(3) and 236 of the 1961 and 1968 housing acts (which was the focus of the Commission's study) will be lost to low-income households at the end of 15 years. Owners of 280,000 units will default on their mortgages, allowing the properties to revert to the Federal Government for disposition. Owners of another 243,000 units will likely convert them to market-rent apartments, sell them as condominiums, or use them for other higher income purposes. Only 122,000 would remain for use as low-income housing. According to the report, two groups—the elderly and large families—are most likely to be hurt by prepayments and defaults as they are least able to cope with displacement or find comparable replacement housing. It will also hurt those with the lowest incomes—70 percent of the tenants of the threatened housing stock have incomes below 50 percent of the median for their area.

A report released in February 1988 by the National Housing Preservation Task Force states that the major threat to the inventory of low- and moderate-income housing comes not from prepayment of mortgages, but rather from expiring Section 8 subsidy contracts. According to the report, over 700,000 units could be lost by 1995; if owners choose to opt out of their contracts early, the loss could approach 1 million units by 1995 and 1.4 million by 2000.

Although the present need for affordable housing and shelter assistance argues for increased Federal efforts and resources, fiscal concerns over the growing budget deficit continue to make these programs targets for budget savings. The net effect of these fiscal constraints resulted in a policy shift by the Reagan administration toward other approaches for meeting the housing needs of older persons. President Reagan was successful in shifting the mix of additional units assisted by HUD from the more expensive new construction and substantial rehabilitation types to existing units leased in the open market. Under that administration, the primary emphasis with regard to public housing for the elderly became preservation, maintenance, and rehabilitation of the existing housing stock.

The Bush administration's emphasis on using existing housing is based not only on cost considerations but also on the belief that there is an adequate supply of low- and moderate-income rental housing in most areas of the country. The administration has contended that the need for housing assistance in America can be met most efficiently by providing Section 8 certificates or, preferably, vouchers to eligible families for existing rental housing.

Nonetheless, a large percentage of new construction of housing over the past 10 years has been for the elderly. The relative lack of management problems and local opposition to family units make elderly projects more popular. Yet, even with this preference for the construction of units for the elderly, in many communities there is a long waiting list for admission to projects serving the elderly. Such lists can be expected to increase as the demand for elderly rental housing continues to increase in many parts of the Nation.

1. HOME Investment Partnership Act

The HOME Investment Partnership Programs (HOME) are the centerpiece of the recently passed National Affordable Housing Act. HOME provides grants to States and local jurisdictions to promote local initiatives in providing housing assistance. This provision is a reaction to the widely held belief that HUD administration of housing assistance has been rigid and unresponsive to varying local markets and needs. Although many believe the local flexibility is desirable, there is concern about the administrative capability of many jurisdictions, as well as concern about the degree to which localities will carry out Federal housing policies, such as income targeting and fair housing requirements. To meet these concerns, procedures for reporting and HUD review of plans and activities are included.

"Participating jurisdictions" are those local governments and States which meet requirements by filing a housing strategy. Local jurisdictions must also meet threshold allocation amounts or alternative requirements. HUD establishes a HOME Investment Trust Fund for each participating jurisdiction. Funds are allocated by formula, with matching funds required in proportions depending on the use to which they are put. To permit authorization of funds in the current deficit-reduction atmosphere, funding is prohibited after fiscal year 1991 for the Housing Development Action Grants program (HoDAG), the Section 17 rental rehabilitation program, Section 312 rehabilitation loans, Section 8 moderate rehabilitation (except for single-room occupancy rehabilitation authorized by the McKinney Act), the Nehemiah homeownership program, and the urban homesteading.

Funds may be used for acquisition, new construction, rehabilitation, and tenant-based assistance. Rehabilitation of substandard housing will be the predominant use of HOME funds, however, some funding will go to new construction. Funds may be used for new construction only if the supply of housing at rentals below the fair market rent is inadequate to meet the existing needs of residents. Construction may also take place if there is a shortage of housing suitable for rehabilitation.

Of the funds appropriated for the HOME Investment Partnerships, only 10 percent in fiscal year 1991 and 15 percent in fiscal year 1992 would be designated for use only to produce affordable rental housing through new construction or substantial rehabilitation. Funds may not be used for public housing operating subsidies or modernization. Uses are to be targeted to assisting low- and moderate-income families. For rental housing, at least 90 percent of the funds are for families with incomes no higher than 60 percent of median and the rest at no higher than 80 percent of median. This reaffirms the policy that Federal housing assistance should be directed, wherever feasible, toward rent for low-income beneficiaries to within 30 percent of the family's adjusted income.

For funds used for homeownership, all assisted units must be occupied by families with incomes no greater than 80 percent of the median. Other requirements are established, as to price and rent levels, rent-income ratios, as well as others. Jurisdictions are required to maximize public-private partnerships, and at least 15 percent of each jurisdiction are to be reserved for 18 months as a set-aside for nonprofit community housing development organizations.

The home repair service grant program, under the HOME Investment Partnership Act, makes grants available to older and disabled individuals, as well as to eligible organizations, for home repair services. This model program would provide guidelines for a participating jurisdiction to repair primary residences only to those qualifying as low-income families. The services may include examination of homes, repair services, and follow-up to ensure continued effectiveness of the repairs provided.

Congress authorized $1 billion in fiscal year 1991 and $2.1 billion in fiscal year 1992 to be appropriated for the HOME Investment Partnerships Act. Sixty percent of the Federal funds will go to local governments and 40 percent to the States. In addition, the Secretary must reserve 1 percent of the total amount appropriated by Congress to go to Indian tribes. Jurisdictions must contribute a match of 25 percent for rental assistance and housing rehabilitations. For substantial rehabilitation, the State or local government must contribute 33 percent, and for new construction, the jurisdiction must provide a match of 50 percent. No funds were appropriated for fiscal year 1991.

2. Tax Reform and Tax Credits

The largest Federal housing programs do not concentrate on low-income households, but rather reward the largely upper income homeowners through the deduction of mortgage interest and property tax. The latter is probably more important to elderly owners since many have fully paid their mortgages. In addition, homeowners age 55 and older are excluded from capital-gains taxation. These housing tax expenditures resulted in more than $54 billion in annual deficit.

While property taxes remain fully deductible, the Omnibus Budget Reconciliation Act of 1987 (OBRA 1987) placed a limit on the amount of mortgage interest that can be deducted. OBRA 1987 limits the total mortgage interest on a principal and second residence that can be deducted on debt of up to $1 million incurred after October 13, 1987. This, of course, is likely to be of little concern to most homeowners. However, since for most homeowners, the amount of deductible mortgage debt is equal to the current amount of their mortgage, and under the new law this is reduced as the mortgage is paid down, some care should be made not to prepay the mortgage with funds that they may need in the near future. This concern is considerably reduced for most owners by another OBRA 1987 provision that allows interest to be deducted on up to $100,000 of home equity loans.

A number of important tax incentives having to do with the provision of rental housing were reduced or eliminated under the Tax Reform Act of 1986. There is a less generous depreciation schedule, limitations on the amount of rental loss that can be deducted by an investor, and the end of preferential capital gains taxation. Construction of new rental properties has dropped significantly in many parts of the country since 1986.

To increase the supply of rental housing units available and affordable to low-income households, including the elderly, the 1986 tax act created a new low-income housing tax credit for a 3-year period (1987 through 1989). The purpose of the low-income tax credit is to enable investors to apply for 10 years of tax credits for new construction, or for the substantial rehabilitation or purchase of existing buildings, where a specified percentage of units are set aside for low-income renters for at least 15 years.

The Omnibus Budget Reconciliation Act of 1989 (OBRA 1989) extended the tax credit for 1 year, through December 31, 1990. OBRA 1989 also requires a 30-year extended low-income use agreement for credit eligibility. However, the law allows for conversion of the property to market rate use, under specified circumstances, but provides that existing low-income tenants may not be evicted within 3 years after the end of the compliance period. OBRA 1989 eliminated the availability of the tax credit to property receiving assistance under HUD's Section 8 moderate rehabilitation programs.

The fiscal year 1991 budget reconciliation bill extends the low-income housing credit program through the end of 1991. In addition, the new law establishes the maximum number of 1991 tax credits that can be allocated in State to be $1.25 per capita. A technical amendment denies the 70 percent present value tax credit to any project that receives Section 8 moderate rehabilitation assistance during the minimum 15-year compliance period. Prior tax law had eliminated the 30 percent present value tax credit to any building receiving moderate rehabilitation funds at any time during the 10 year tax period. Included in the 1990 tax law is a provision to reduce the maximum annual deduction by individual taxpayers for expenditures to remove architectural and transportation barriers which prevent access by disabled persons. The maximum annual deduction was reduced from $35,000 to $15,000.

3. Prepayment

During the next 12 years, more than 360,000 units of federally assisted housing may be withdrawn from the affordable housing supply by their owners. Contracts entered into by the Federal Government and private developers under low-interest loan programs during the 1960's (Section 236 and Section 221(d)(3)) permitted certain owners to prepay the federally assisted mortgage after the 20th year of the 40-year mortgage term. A mortgage prepayment and termination of the mortgage insurance contract ends Federal restrictions over the use of the property for the benefit of low- and moderate-income households. In addition, an unknown number of the 850,000 project-based Section 8 assisted units may choose to "opt-out" of their contracts, or their contracts may expire within that same time period.

The reasons for prepayment vary. The projects may be in a condition and/or location that permits profitable sale for conversion to condominiums or to nonresidential use. In some instances (in Section 202 projects, for example) the borrowers argue that many projects are old and have suffered extensive deterioration as maintenance has been deferred. With many of these projects heavily in debt and unable to raise rents to support the cost of repairs, the project owners say that they have no way of rehabilitating the premises. Owners claim that if they were allowed to prepay their loans, the projects could be sold to profit-motivated owners who could afford private financing for needed repairs.

The GAO estimates that by 1995, the combination of expiring rent subsidies (i.e., 15-year Section 8 contract periods) and potential mortgage prepayments could reduce the current inventory of privately owned low- and moderate-income rental housing by 200,000 to 900,000 units. According to the National Association of Home Builders, it would cost more than $130 billion to replace the existing stock of such housing.

Housing activists fear that a monumental housing crisis is in the making. They note that this potential reduction comes at a time when Federal subsidies for low-income housing have been reduced by more than 70 percent over the past 8 years. Furthermore, tax reform has eliminated much of the incentive to invest in low-income housing.

The Housing and Community Development Act of 1987 established a temporary measure to give Congress time to develop a permanent program for the preservation of this housing. During this time, much was learned about the financial, tax, and regulatory aspects of the prepayment issue. More importantly, according to the NAHA conference report, a consensus finally emerged on how best to strike the balance of interests of owners, the tenants, and the communities most affected by the consequences of prepayment. The fundamental principle of the 1987 act was that the housing should be preserved for its intended beneficiaries and that owners should be guaranteed a fair and reasonable return on their investment through new incentives. While the principle of the 1987 act is retained, the 1990 legislation transforms the goal of a fair and reasonable return into a set of concrete economic alternatives for the owner that can be pursued through a more objective streamlined process.

NAHA 1990 permits prepayment in the very limited circumstance, also applicable in the 1987 act, that HUD finds that the removal of a project from the federally assisted housing stock will not materially increase hardship for current tenants. In addition, tenants can not be involuntarily displaced as a result of prepayment for a project unless comparable housing is readily available without rental assistance. Owners seeking to prepay must ensure that the result of such action will not materially affect the availability of affordable housing to other low- and very-low-income families and minorities near their employment opportunities because sufficient vacancies exist. Prepayment is permitted if HUD cannot fund sufficient subsidies, referred to as "incentives," to provide owners with a fair return on their equity when low-income use is continued, or if a buyer willing to continue such use, with HUD subsidies, cannot be found to purchase at a fair market price. Tenants are given a number of protections in the determination process, and assistance is provided if the owner is allowed to prepay.

The prepayment plan under the 1990 Housing Act provides complex paths of procedures to be followed by the owner, by HUD, and by a possible purchasers. In all cases, it begins with the filing of a statement of intent by an owner already eligible or who will become eligible to prepay his mortgage, that he wishes to prepay, to continue operation with additional subsidy, or to sell. After the statement process, the procedures vary.

If an intent to prepay was indicated, but denied, or if one of the other alternatives was chosen, an appraisal process is established, and fair market rents, fair return on equity, fair market price, and Federal cost limits, as defined in the Act, are determined. HUD may offer a variety of "incentives," sufficient to cover the operating expenses and a fair return of profit, which is defined as an 8 percent on equity. If HUD is able to offer the owner that fair market return, the owner would be required either to maintain affordability restrictions on the housing or to transfer the housing to a qualified purchaser that will.

These incentives may take on many forms such as increased access to residual receipts, increased rents, additional Section 8 assistance, financing of improvements, as well as others. When a project is for sale, nonprofit and public agencies are given first priority for a period of time. If no sale results, the purchase is opened to any qualified buyer who will maintain the low-income rental use. This process, due to the established time limits, could take several years to complete.

The prepayment of any projects carries with it many restrictions and financial requirements to serve as protective measures for tenants. Tenants must be offered Section 8 assistance, subject to fund availability, and if owners, after prepaying continue the project as a market rental, they must accept Section 8 tenants. Three-year extensions of leases are to be given to tenants with special needs, and to all tenants in low-vacancy areas. If a tenant must be relocated, the owner is required to pay 50 percent of relocation costs. State or local law can require this amount to be greater.

Physical deterioration or financial difficulty can result in the loss of a project to the assisted housing stock. Under the Section 221(d)(3) and 236 programs, rents are controlled by HUD, in accordance with a prescribed formula in each program. Many owners have been discouraged from proper maintenance and additional investment for improvements by insufficient rents to permit an adequate return. HUD is authorized to permit rent increases sufficient to allow a return of advanced capital with interest, provided that rents do not exceed the lower of 30 percent of income or the Section 8 fair market rent for comparable housing. Section 8 assistance is to be provided for adversely affected tenants.

4. PROGNOSIS

NAHA 1990 is the first major housing legislation since 1974. It continues, with some amendment, the major ongoing programs such as public housing and Section 8, and it created a number of new programs as well, such as the HOME Investment Partnership

Act. This new program establishes a block grant to localities and States. Essentially, a Home Investment Trust Fund will offer a line of credit to each participating jurisdiction for assistance. Both the Congress and the administration have indicated their commitment to this effort, recognizing that the Nation's housing problems, including those faced by the elderly, are not going to resolve themselves and cannot be handled by the Federal Government alone. States, local communities, and the private sector must play active roles in assuring assisted housing for those in need.

In light of the limited new housing construction, the preservation of affordable housing stock is essential if the goal of providing affordable, decent, and safe housing is to be met. NAHA attempts a permanent solution to the threat of prepayment, and only in very limited circumstances will the owners be allowed to prepay.

Finally, the new housing legislation provided a number of incentives to promote homeownership. While many feel these efforts would be better spent to providing the benefits to low-income tenants of rental properties, the administration continues to push its agenda of "empowerment" through homeownership, as seen through the new HOPE programs and the changes in the tax credit system.

D. INNOVATIVE HOUSING ARRANGEMENTS

Alternative housing options are necessary to meet the needs of the elderly population that does not require institutional care, but is unable to live independently, due to financial or health reasons. Several types of solutions to the problems of those elderly living in houses too large for their needs and too costly to maintain have surfaced. In addition, concern about meeting the needs of those older persons who have become too frail to live independently without adequate supportive services has led to increased attention to developing and utilizing alternatives. Among the housing alternatives that continue to receive attention are continuing care retirement communities, shared housing, and ECHO, or "granny flat" arrangements.

1. Continuing Care Retirement Communities

Continuing care retirement communities (CCRCs), also called life-care communities, typically provide housing, personal care, nursing home care, and a range of social and recreation services as well as congregate meals. Residents enter into a contractual agreement with the community to pay an entrance fee and monthly fees in exchange for benefits and services. The contract usually remains in effect for the remainder of a resident's life.

The definition of CCRCs continues to be confusing and inconsistent due to the wide range of services offered, differing types of housing units, and the varying contractual agreements. According to the American Association of Homes for the Aging (AAHA), "continuing care retirement communities are distinguished from other housing and care options for older people by their offering of a long-term contract that provides for housing, services and nursing care, usually all in one location." In its study on life care, the Pension Research Council of the University of Pennsylvania developed a definition of life-care communities. It includes providing specified health-care and nursing home care services at less than the full cost of such care, and as the need arises.

There are approximately 700–800 continuing care retirement communities with an estimated 230,000 residents, which represents about 1 percent of the elderly population. While most life-care communities are operated by private, nonprofit organizations and some religious organizations, there has been an increasing interest on the part of corporations in developing such facilities.

CCRCs are often viewed as a form of long-term care insurance, because communities protect residents against the future cost of specified health and nursing home care. Like insurance, residents who require fewer health and nursing home care services in part pay for those who require more such services. Entrance fees are usually based on actuarial and economic assumptions, such as life expectancy rates and resident turnover rates, which is also similar to insurance pricing policies.

In 1988, the median CCRC entrance fees ranged from approximately $32,800 for a studio, $47,500 for a one bedroom, and $68,250 for a two-bedroom unit. The median monthly fees ranged from $695 for a studio, $830 for a one bedroom to $938 for a two-bedroom. This wide range results from such factors as the social and health care services provided, the size and quality of independent living units, and the amount of health care coverage provided. CCRCs do not usually cover acute health care needs such as doctor visits and hospitalization. Studies have shown that the average age of persons entering life-care communities is 75. In independent living units, personal care units, and nursing home units the average ages are 80, 84, and 85, respectively.

Problems have been discovered in some communities, such as those using lifespan and health projections that are not actuarially sound, as well as incorrect revenue and cost projections. Some contracts are written in such a way that if a person decides, even within a reasonable period of time, that he or she does not want to stay at the facility, the entire endowment is lost and not returned, even on a prorated basis. According to AAHA's guidebook to CCRCs, the many variations of contracts can be grouped into three types: extensive, modified, and fee-for-service. All three types of contracts include shelter, residential services, and amenities. The difference is in the amount of long-term nursing care services provided. The extensive contract includes unlimited long-term nursing care. A modified contract has a specified amount of long-term nursing care. This specified amount may be 2 months, for example, after which time the resident will begin to pay a monthly or per diem rate for nursing care. The fee-for-service contract guarantees access to the nursing facility, but residents pay a full per diem rate for all long-term nursing care required. Emergency and short-term nursing care may, but not always, be included in the contract. (The consumer guidebook for CCRCs is available from AAHA.)

Recently, there has been a growth in the number of private nonprofit corporations which sponsor life-care facilities. While the individual facility is clearly nonprofit, the corporation that organizes and develops the project is often a for-profit organization. The profitmaking goals of the developer may conflict with the financial stability of the nonprofit corporation. For example, to attract consumers and quickly raise funds, the pricing structure may be established too low to provide both profit and future financial stability.

While most CCRCS are managed effectively, some have faced financial and other problems. A growing phenomenon, life care is just beginning to be understood and regulated. California, in 1939, was the first State to regulate life care. Today, more than 30 States regulate the operation of life-care communities. There is little uniformity, however, in the way these facilities are regulated by the States. Some States require operators to make public ownership and financial disclosures, others do not. Similarly, some States regulate resident rights and others do not. Few, if any, of the States offer adequate protection from the operator who deliberately seeks to use complex profit/nonprofit business structures to enhance his personal wealth at the expense of the CCRC residents.

Problems in some CCRCS raised concerns by many in Congress that participants be allowed to recoup entrance fees under certain circumstances. The Internal Revenue Code, however, treated refundable entrance fees as "loans" to the CCRC and imputed interest on the down payment as income received by the elderly resident. This was viewed as a hardship to life-care community residents, and in 1985 Congress enacted a proposal by Senator Heinz which exempted the first $90,000 of an entry fee from the IRS's imputed interest rules as part of Public Law 99-121. The House version of the 1987 reconciliation bill contained a provision to repeal the exemption and reinstate the imputed tax treatment on the entire amount of a refundable entrance fee. This proposal was rejected by the conference committee and was not contained in the bill as passed (P.L. 100-202).

Supporters of CCRCS contend that there are a number of benefits associated with this concept. For example, the pooling of resources and risks may help to reduce the uncertainties of future costs of care, and there are greater opportunities for residents to maintain their health as health care and other services are provided on a regular basis. CCRCS are an option for some elderly, but it is unlikely that many with low and moderate incomes would be able to afford it.

2. SHARED HOUSING

Shared housing can be best defined as facilities housing at least two unrelated persons where at least one is over 60 years of age, and in which common living spaces are shared. It is a concept which targets single and multifamily homes and adapts them for elderly housing. Shared housing can be agency-sponsored, where 4-10 persons are housed in a dwelling, or it may be a private home/shared housing situation in which there are usually 3 or 4 residents.

The economic and social benefits of shared housing have been recognized by many housing analysts. Perhaps the most easily recognized benefit is companionship for the elderly. Also, shared housing is a means of keeping the elderly in their own homes, while helping to provide them with the means to maintain these homes. In some instances, elderly who otherwise would be overhoused can help families who may be having difficulties in finding adequate housing arrangements.

According to census statistics, some 670,000 people over 65 (excluding those who are institutionalized or in nursing homes) share housing with nonrelatives; a 35-percent jump over a decade ago. From an economic viewpoint, shared housing can be an important low-cost means of revitalizing neighborhoods. Abandoned houses and buildings could be made suitable for shared housing with very little renovation. Shared housing is extremely cost effective when compared to new construction. The per unit capital costs could be 50 to 60 percent lower using shared housing.

There are various impediments to shared housing. Among the most prominent are zoning laws and reduced SSI and food stamp payments to participants. Congress has recognized and begun to act on the need to overcome them. The Housing Act of 1983 included a provision allowing the existing and moderate rehabilitation programs of Section 8 rental assistance to be used to aid elderly families in shared housing.

There are a number of shared housing projects in existence today. Anyone seeking information in establishing such a project or looking for housing in a project can contact two knowledgeable support services. One is Operation Match, which is a growing service now available in numerous communities throughout the country. It is a free public service open to anyone 18 years of age with no sex, racial, or income requirements. Operation Match is a division in the housing offices of many cities. It helps match people looking for an affordable place to live with those who have space in the their homes and are looking for someone to aid with their housing expenses. Some of the people helped by Operation Match are single working parents with children, those in need of short-term housing, elderly people hurt by inflation or health problems, and the handicapped who require live-in help to remain in their homes.

The other source of information in shared housing is the Shared Housing Resource Center in Philadelphia. It was founded in 1981, and acts as a link between individuals, groups, churches, and service agencies that are planning shared households.

3. ACCESSORY APARTMENTS AND GRANNY FLATS

Accessory apartments have been accepted in communities across the Nation. These apartments were occupied by members of the homeowner's family, and, therefore, accepted into the neighborhood. Now, with affordable rental housing becoming more difficult to find, various interest groups, including the low-income elderly, are taking a closer look at this type of housing.

Accessory apartments are another form of shared housing, except that each unit has it own kitchen. As a result, this form of housing undergoes the same zoning restrictions and impediments previously mentioned in the shared housing discussion. Approximately 40 percent of the single-family housing stock in the country is now zoned to permit accessory apartments. Once zoning is changed in a community, there are typically a number of applications to legalize existing accessory apartments, but very few applications for new ones. The reason is that the homeowners must deal with local government zoning and building regulations, as well as with contractors, banks, and tenants. Unfortunately, the process is intimidating for many people and it is difficult to find reliable advice. A basic partnership between real estate agents and remodelers to market accessory apartments could provide some assistance in understanding this often complex issue.

Another innovative housing arrangement under discussion is the "granny flat" or "ECHO" flat, first constructed in Australia and recently introduced in this country. Granny flats were constructed as a means of providing housing for elderly parents or grandparents where they can be near their families while maintaining a measure of independence for both parties. In the United States, we refer to such living arrangements as ECHO units, an acronym for elder cottage housing opportunity units. ECHO units are small, free standing, barrier free, energy efficient to existing single-family houses. Usually they are installed on the property of adult children, but can also be used to form elderly housing cluster arrangements on small tracts of land. They can be leased by nonprofit corporations or local housing authorities.

Rigid zoning laws, lack of public information, and concern about adverse changes to the neighborhood, and therefore, property values, are the major barriers to the development of ECHO housing. Many civic leaders, public officials, and organizations are reporting increased interest in the possibility of ECHO units for their jurisdictions. At this time, there is no Federal legislation dealing with this concept.

4. Prognosis

Innovative housing programs are essential to providing basic housing and supportive services for our Nation's elderly, handicapped, and poor. Congress, however, must take a serious look at the development and expansion of many of these programs as they continue to increase in number. Additional studies are needed to look at the promising aspects of these alternative housing options, as well as the prevalence of fraud and abuse.

The life-care industry, as well as the development of other private retirement facilities, is expected to grow in the next several years, mainly appealing to the upper middle and upper income groups. Some are examining options for developing life-care facilities for lower income Americans, primarily those that have been able to purchase a home and have built up equity during their lifetime. This effort will evolve slowly, however, and will be undertaken primarily by nonprofit life-care interests.

Shared housing will become a more necessary option for older Americans in future years as the cost of maintaining a single residence becomes a larger burden than many elderly can afford. The need for quality accessory apartments and granny flats, and other innovative approaches, will only continue to grow with the increase in the number of older Americans. The focus will be on reinvigorating the overall Federal role in meeting the housing needs of America's low-income citizens, and in providing ways for the disabled and those who have "aged in place" to obtain services, so that they can continue to live semi-independently.

E. HOMELESS SERVICES

The plight of the homeless has emerged as one of the Nation's most pressing concerns. The most troubling aspect of the homeless issue is that no reliable statistics exist to determine the number of homeless persons. Recent attempts by the U.S. Bureau of the Census to interview homeless people for the decennial census encountered various problems, including an insufficient supply of census forms, lack of cooperation from some shelter providers, and criticism that many sites frequented by the homeless were overlooked. Current estimates of the number of homeless persons range from 250,000 to 3 million.

While no one knows precisely how many Americans are hungry or malnourished, institutions involved in providing emergency food assistance have seen dramatic increases in the numbers of people seeking assistance during the past few years. According to a survey of 30 major cities released in December 1990 by the U.S. Conference of Mayors, requests for emergency food assistance increased by an average of 22 percent. Due to limited funds and other resources, an estimated average of 14 percent of the requests for emergency food assistance have gone unmet, thus forcing the emergency food resources facilities to turn people away.

Homelessness stems from a variety of factors, including unemployment, social service and disability cutbacks, lack of aftercare services for the deinstitutionalized mentally ill, noninstitutionalization (the failure to treat people who need a hospital environment), personal crises, substance abuse, and housing shortfalls in urban areas. The homeless with chronic mental illness comprise between one-fourth and one-third of the estimated homeless population. The fastest growing segment among the homeless, however, is unemployed individuals and their families. Recent studies also have documented a new category of homeless—the suburban homeless, or the working poor. Members of this population may live in relatively affluent suburban communities, but with rising housing costs, families who earn the minimum wage, or barely above it, cannot afford apartments or houses. Instead, they are living on the streets, in publicly funded shelters, or in their automobiles.

A 1987 report by the National Coalition for the Homeless estimates that 15 to 20 percent of the homeless are over age 60. Homelessness among the elderly stems largely from the lack of affordable housing due to skyrocketing rents, the elimination of single-room-occupancy hotels, and a shrinking supply of low-income housing. Given the decline in Federal housing assistance, the housing needs of low-income households currently cannot be met. In the meantime, the number of people on waiting lists for low-income public housing continues to rise.

During the early 1980's, the policy of deinstitutionalization was credited as a leading cause of homelessness in America. However, deinstitutionalization was initiated over 25 years ago, and most surveys report that only a modest percentage of homeless persons are former residents of mental hospitals. Today, many observers believe that "noninstitutionalization" (individuals' lack of access to or choice of mental health treatment) is a critical factor contributing to homelessness.

In the past, Congress responded to the problem of homelessness with legislation that was essentially of an emergency nature, primarily because homelessness was perceived as a temporary crisis. The major programs authorized in the 98th Congress were the Emergency Food and Shelter Program (P.L. 98-8), funded through the Federal Emergency Management Agency (FEMA), and the Temporary Emergency Food Assistance Program (TEFAP), administered by the Department of Agriculture (P.L. 98-92). In the 99th Congress, statutes governing various welfare programs were amended to provide for the needs of the homeless through provisions included in the Homeless Eligibility Clarification Act (Title XI of the Anti-Drug Abuse Act of 1986, P.L. 99-570). Among the new provisions were removal of restrictions limiting food stamp eligibility of homeless persons living in shelters, Supplemental Security Income payments to eligible homeless persons, and establishment of methods of delivering veterans' benefits to persons lacking a mailing address.

Legislative efforts to expand assistance to the homeless were among the first items on the agenda of the 100th Congress. Most Members of Congress believed that solutions to the problem of homelessness should be developed at the local level, but that the Federal Government should play an important role in the solution as well. In January 1987, Congress passed a measure reallocating $5 million in disaster relief funds to programs aiding the homeless (P.L. 100-6).

Congress followed up with the Stewart B. McKinney Homeless Assistance Act which was signed into law on July 22, 1987 (P.L. 100-77). In parallel action, congressional conferees for the fiscal year 1987 supplemental appropriations bill, H.R. 1827, agreed to appropriate most of the funds for the programs included in the McKinney bill. The appropriations measure also was signed into law in July 1987 (P.L. 100-71).

The 101st Congress took a serious look at homelessness and the programs previously established to address the problem. When Congress reauthorized the Stewart B. McKinney Homeless Assistance programs (P.L. 101-645), it strengthened the homeless prevention components, most notably through the provision of supportive services within public housing. In addition, NAHA 1990 contains sections that are consistent with the thrust toward homelessness prevention and comprehensive, on-site social services.

1. STEWART B. MCKINNEY HOMELESS ASSISTANCE ACT

(A) LEGISLATIVE BACKGROUND

The primary response of the Federal Government to the plight of the homeless has been through the McKinney Homeless Assistance Act of 1987. This legislation, however, authorized programs only through fiscal year 1988. Consequently, an omnibus measure authorizing a 2-year extension of the programs was introduced in the House of Representatives on March 31, 1988, as H.R. 4352. The conference report on H.R. 4352 passed in the House on October 19, 1988, and in the Senate on the following day. The bill was signed by the President on November 7, 1988, and became Public Law 100-628.

In addition to reauthorizing existing programs under the McKinney Act, the new law incorporated provisions for homeless veterans and the "Jobs for Employable Dependent Individuals Act" (JEDI) to improve job training and placement for long-term welfare recipients.

The materials accompanying President Bush's proposed revision of the Reagan administration's fiscal year 1990 budget proposals did not specify the funding levels in detail, but stated clearly that Bush was seeking funding for McKinney Act programs up to their full authorization levels—totaling $676 million. The amount initially appropriated in fiscal year 1990 for McKinney Act programs was approximately $600 million (see Table I). Sequestration under Gramm-Rudman and the redistribution of money for emergency drug funding led to a revised fiscal year 1990 total of $596.2 million for major McKinney Act programs.

The Bush administration's fiscal year 1991 budget request for current McKinney Act programs (see Table I) totaled $586.8 million. The appropriations law for fiscal year 1991 (P.L. 101-507 and P.L. 101-517) do not contain detailed funding tables for each specific McKinney Act program, but the available information indicates fiscal year 1991 levels of at least $650 million.

The Departments of Veterans Affairs and Housing and Urban Development and Independent Agencies Appropriations Act of 1991 (P.L. 101-507) made the following appropriations for the McKinney Act programs under its jurisdiction: $134 million for the Federal Emergency Management Agency (FEMA); $339 million for HUD; and $30 million for Veterans Affairs. The Department of Labor, Health and Human Services, and Education and Related Agencies Appropriations Act of 1991 made the following appropriations for McKinney Act programs: $120 million for HHS (not including an unspecified amount for emergency assistance demonstration grants to phase out "welfare hotels"); $17 million for education; and $11 million for labor.

The Stewart B. McKinney Homeless Assistance Amendments Act of 1990 included modest increases in authorization levels and some redefinition and expansion of services. Specifically, the act reauthorizes the following: InterAgency Council on the Homeless; FEMA Emergency Food and Shelter Program; HUD Emergency Shelter Grants Program, Supportive (Transitional) Housing, Supplemental Assistance, Section 8 Single Room Occupancy (SRO) Assistance; HHS Health Care for Homeless block grant, Mental Health Care for Homeless block grant, Mental Health Demonstrations for Homeless, Substance Abuse Demonstrations for Homeless; HHS Job Training for the Homeless; HHS Emergency Community Services for the Homeless block grant; ED Adult Literacy for Homeless Program, Education for Homeless Children and Youth, Exemplary Grants for Dissemination Program; and VA Medical Programs for Homeless Veterans.

Title VI also establishes family support centers located at or near government-subsidized housing to provide comprehensive services to low-income families who were previously homeless or who are at risk of becoming homeless. Although a number of new programs involving social services in publicly assisted housing were incorporated into the reauthorization of the McKinney Act, no fiscal year 1991 appropriations were made for these new programs.

In addition, the Bush administration proposed a new HUD program—"Shelter Plus Care"—which would provide assistance to long-term homeless people who are mentally ill or have substance abuse problems. The program was intended to be part of the HOPE grants that HUD Secretary Jack Kemp advocated, and elements of these proposals were incorporated into the Cranston-Gonzalez National Affordable Housing Act (P.L. 101-625).

TABLE 1: FY 1990 and FY 1991 Funding for Major McKinney Act Programs

[In millions of dollars]

Department or Agency	FY 1990 Appropriation	FY 1990 Adjusted [1]	Bush FY 1991
Federal Emergency Management Agency: Emergency Food and Shelter	134.0	130.0	125.0
Housing and Urban Development:			
Emergency Shelter Grants	[2] 75.0	73.7	71.2
Supportive (Transitional)	[2] 130.0	126.8	143.4
Supplemental Assistance	[2] 11.0	10.8	....
Section 8 (SRO)	[2] 75.0	73.2	49.6
Health and Human Services:			
Health Services for Homeless	[3] 34.1	33.7	[4] 45.6 (12)
Community Services for Homeless	[3] 22.0	21.8	[4] 42.0 (8)
Community Mental Health	[3] 28.1	27.7	[4] 34.0 (7)
Mental Health Demonstrations	[3] 6.1	6.0	6.0
Alcohol/Drug Demonstrations	[3] 9.5	16.3	[4] 9.5 (.5)
Homeless AFDC Families Demonstration	[3] 20.0	20.0	(5)
Education:			
Adult Literacy	7.5	7.4	10.0
Youth and Children	7.5	7.4	7.5
Labor: Job Training (includes Veterans' Reintegration)	11.5	11.3	11.5
Veterans Administration:			
Mentally Ill Veterans	11.5	15.0	15.0
Veterans' Domiciliary Care	11.5	15.0	15.0

[1] Incorporates emergency drug funding and GRH sequestration, according to Administration budget documents.

[2] H.R. 2916, Conference Report 101-297. (P.L. 101-144)

[3] H.R. 2990, Conference Report 101-274. (P.L. 101-166)

[4] These FY 1991 funds were advanced FY 1991 appropriations included in P.L. 101-156 (see Conf. Rept. 101-274). The FY 1991 Bush proposal includes these advanced appropriations.

[5] The Bush proposal would move this program to HUD's supportive (transitional) housing program and is reflected in the increased FY 1991 request for that program.

(B) IMPLEMENTATION OF THE 1987 MCKINNEY ACT PROGRAMS

In oversight and reauthorization hearings in 1988, Congress expressed concern over the slowness of HUD's approval of the suitability of surplus Federal structures that could be made available to the homeless. In 1989, approximately 4,800 excess and unused Federal properties were reviewed and just under one-half of those reviewed were found to be suitable for use by the homeless. Advocates for the homeless filed a lawsuit against HUD, the GSA, and three other Government agencies in an attempt to accelerate Federal action. A Federal court subsequently ordered HUD to review the surplus Federal properties for possible use by the homeless within 1 month. HUD remains under the same court order.

There has been congressional concern over whether the Inter-Agency Council on the Homeless has been fulfilling its duties. The Council was created by the McKinney Act to review and evaluate Federal agencies, to work with States and local governments to coordinate programs, and to develop new programs for the homeless, and to report to Congress. Due to the Council's unresponsiveness to congressional inquiries, in April 1989, the GAO was asked to undertake an investigation of what steps the InterAgency Council on the Homeless had taken to improve its implementation of the Stewart B. McKinney Homeless Assistance Act.

In July 1990, GAO published "Homelessness: Changes in the InterAgency Council on the Homeless Make It More Effective" in response to the congressional request. According to the GAO report, the leadership of the Council has improved substantially since March 1989. For example, the Council's field coordination efforts have improved since 10 HUD employees were designated to serve on a full-time basis as regional coordinators to provide technical assistance to State and local providers. In addition, the report highlighted the improvement of the Council's policy recommendations published in the 1989 annual report. The 1988 report contained general policy recommendations, but did not discuss the level of Federal assistance necessary to alleviate homelessness. The 1989 report, however, focuses primarily on the Federal response to the homeless issue. The GAO recommended that the Council's goals and responsibilities continue to be clearly defined to ensure that urgently needed assistance intended by Congress and the McKinney Act will be provided to the homeless.

2. PRIVATE AND PUBLIC SECTOR ROLES

Although homelessness is a problem that deserves the attention of policymakers, Federal responsibility for the homeless continues to be a matter of considerable debate. The administration and others maintain that the problem is best addressed at the local level through religious and charitable groups. Others maintain that the problem would be better addressed through a comprehensive set of federally assisted programs and benefits. The pro-active approach to homeless views the problem as prevalent across America and beyond the capacity of State and local responses. Those adhering to this approach maintain that the Federal Government should assume responsibility for alleviating the problems that contribute to homelessness because the causes can best be addressed nationally.

Current responsibility for the homeless is dispersed among all levels of government. The Federal programs generally require local- and State-level planning and integration. The largest single Federal appropriation is coordinated, dispersed, and monitored by a national board of local charities and religious organizations. However, it is administered by FEMA.

Another issue of importance is the extent to which the Federal Government can or should be involved in addressing homelessness issues. Even if services were readily available, an unknown portion of the population may be reluctant to accept them, raising essential questions of what can or should be done to deliver services to them. An indication of this problem has emerged in a few major cities which have or are considering new ordinances to temporarily detain mentally ill homeless or others who refuse to accept shelter from the elements. And because so much of the homeless problem is thought by many to involve the chronically mentally ill, questions have been raised about whether more control can be exerted over patient releases and long-term institutionalization.

Private and public resources have been mobilized to attempt to meet the immediate needs for food and shelter. Shelters and other facilities available to the homeless generally are provided by private groups, sometimes with financial help from local governments. In addition to emergency shelters, some localities provide families or individuals with certificates or vouchers to help pay the rent. Vouchers may also be given to destitute people to enable them to rent rooms in single-room occupancy buildings or hotels.

A new frontier in the law recently has begun to develop concerning the rights of homeless individuals. In the face of housing shortages, homeless people are increasingly turning to the courts for assistance, and judges have started to define their rights. While the Constitution does not explicitly guarantee a right to shelter, judges have ordered State and local officials to provide shelter based upon State constitutions and statutes, and upon provisions in the Federal laws. It can be expected that advocates for the homeless will continue to use the courts to obtain and to enforce the basic rights of the homeless.

One experimental project designed to reach the homeless elderly was conducted by the Indiana Department of Aging with Older Americans Act funds. Three area agencies on aging worked with older persons who were either homeless or marginally housed in an attempt to find long-term housing solutions through employment. An enrolled person received assessment of employment needs and skills, individual counseling, job-readiness training, peer group support through job clubs, wages for work experience, and skills training through existing programs such as the Job Training Partnership Act and Community Services Block Grant programs.

In Boston, a group of concerned citizens formed the Elderly Homeless Coalition and developed a plan to provide rooms and meals, health, mental health, and case management services for the city's homeless elderly.

The Emergency Food and Shelter program, currently administered by FEMA, was initiated in the Emergency Jobs Appropriations Act, approved in 1983 (P.L. 98–8). The program continued through appropriations, supplemental appropriations, and a continuing resolution in subsequent years. The 101st Congress, for example, passed H.R. 2402, making supplemental appropriations for fiscal year 1989 for this program. H.R. 2402 included a $12 million transfer from HUD to FEMA.

By most accounts, the FEMA program, which utilizes local programs rather than duplicating their efforts, has worked well. In 1989, FEMA funded about 29 million fewer meals than it did in 1988, at a cost of $55 million. "Meals" includes meals provided on site, vouchers for meals, and meals from food banks. A meal provided from these funds is estimated to cost 69 cents, on average. The estimated cost of a night in a shelter is $2.94. "Shelter" includes motels/hotels and 1 month's rental assistance as well as actual shelters. The total cost in 1989 for shelters was $50 million.

Citizens in cities across the country have voluntarily donated time and money to help feed the hungry and house the homeless.

But even with these efforts, optimistic statistics revealed that only one in three homeless individuals had a bed and a bowl of soup in a public or private shelter in the winter of 1988. Other figures suggest that only 1 of 20 were so fortunate. Both figures illustrate the extent of the unmet need. A HUD report, for example, states that in 1988, there were about 275,000 shelter spaces available nationwide for as many as 500,000 to 600,000 homeless individuals, indicating a serious shortage. Moreover, these shelters are at risk in many communities because of neighborhood opposition, inner-city redevelopment, and other factors.

3. Federal Housing Programs

Advocates for the homeless, as well as some researchers and housing experts, argue that the lack of affordable housing is the chief cause of homelessness. Federal expenditures for low-income housing continues to decrease while the number of people needing such housing has increased (as discussed earlier in this chapter). In addition, much of the public housing that has been built over the past half century is obsolete and deteriorating.

Homeless advocates argue for a national housing policy that includes a resurgence of Federal spending for the construction and renovation of public housing and for a larger housing voucher program. Some express the belief that reversing to the shortage of low- and moderate-income housing is the only lasting solution to homelessness.

Critics of an expansion of federally assisted housing maintain that such spending cannot be accomplished in a time of Federal deficits and budget constraints, expressing the view that incentives to the private sector are a better way to stimulate housing growth. They also assert that the changes in the Federal Government's housing programs have not caused homelessness. Furthermore, they argue that where there are shortages of low- and moderate-income housing units, it is largely due to local government policies, particularly rent control.

Despite the nearly 4.7 million households receiving renter subsidies through HUD and FmHA programs, approximately 11 million additional rental households are eligible for housing subsidies, but, due to lack of funds, receive no assistance. These households are often described as "on the verge of homelessness" and are frequently the focal point of the homelessness prevention programs that are emerging on the local and State levels.

4. Emergency Shelters and Welfare Hotels

When homelessness originally was thought to be a temporary crisis, it was generally agreed that shelters were a reasonable response. Some now fear that what is called a "shelter industry" has emerged, created in large part by Federal money. This argument states that shelters are transforming from temporary facilities to self-perpetuating institutions. Some maintain that the growth of these shelters has attracted people to homelessness, making nomadic street life and panhandling a viable alternative for those who choose not to be productive members of society.

The use of emergency assistance (EA) and Aid to Families with Dependent Children (AFDC) money to house families in commercial, transient accommodations, commonly referred to as "welfare hotels," is an especially controversial practice. Reports indicate that the costs of housing families in hotels far exceed the normal housing allowance for welfare recipients.

At one end of the spectrum are those who would forbid the use of these funds for such purposes, maintaining that the practice is inappropriate and wasteful. At the other end of the spectrum are those who view the practice as problematic but essential, given the currently available range of programs and services. They point out that AFDC housing allowances often are insufficient, even for low-income housing. Emergency shelter providers also report that they cannot meet the demand for space and that welfare hotels are a last resort.

The McKinney Act authorized a new demonstration grant program for fiscal year 1990 which is intended to reduce the number of AFDC recipients who live in welfare hotels. The Bush administration had unsuccessfully proposed for fiscal year 1991 to move this demonstration program from HHS's Family Support Administration to HUD's Transitional and Supportive Housing Program. An unspecified amount of funds in fiscal year 1991 for this program was included in HHS's Family Support Administration appropriation (P.L. 101-517).

5. INSTITUTIONALIZATION

Some communities are enacting laws that allow local authorities to institutionalize the chronically mentally ill homeless without their permission. For example, a homeless woman sued New York City over her involuntary commitment to a mental hospital. Although the hospital ultimately released the woman, a higher court upheld the local law which provides for involuntary confinement in such cases.

The debate extends beyond the mentally ill homeless to include ordinances that detain any homeless person who refuses to accept shelter from the elements. Questions of civil liberties and rights of the homeless will increasingly become an issue within the judicial system.

As public awareness of homeless issues increased in the early 1980's, deinstitutionalization was credited as the leading cause of homelessness. This conclusion was based, in part, upon national statistics documenting the dramatic decline in number of mental hospital patients, followed by a notable increase in the number of homeless persons. This move toward deinstitutionalization, however, was initiated more than 25 years ago, and more recent surveys report that only a modest percentage of homeless people are former residents of mental hospitals.

6. HEALTH, SOCIAL, AND WELFARE SERVICES

The homeless would clearly benefit from the delivery of health, social, and welfare services. Some maintain that many of the McKinney programs are not necessary because they duplicate existing programs. Community primary health and mental health centers are available to low-income people, including the homeless. When Congress removed requirements that recipients have permanent addresses to obtain certain benefits, it lifted the major legal barrier to providing services to the homeless. Thus, it is argued that instead of special public welfare programs for the homeless, which complicate the provision of services at the local level and are potentially wasteful, local service providers should conduct more outreach to the homeless, thus aiding them with existing programs.

A widely held perspective maintains that funds for the homeless should be distributed as a block grant. This would enable State and local policymakers to make discretionary choices according to the varying needs of individual communities.

Another important policy option is the concept of supportive services within the context of public housing to those who have previously been homeless. The provision of supportive services also serves as a preventive measure. The Bush administration advocated a version of this concept in the HOPE program which would be handled by HUD. Many believe, however, that such human services should be administered by the HHS through local family support centers. HOPE was included in both NAHA and the Stewart B. McKinney Homeless Assistance Amendments Act. No funds were appropriated, however, for these new programs.

7. Prognosis

Homelessness cannot be addressed as if it were simply an emergency situation; homelessness is a chronic condition plaguing this Nation. In the past, legislation provided assistance in the form of emergency shelters and meals, but Congress must take a pro-active approach to the problem and address the causes of homelessness.

The lack of affordable housing and increasing rental rates are major factors contributing to the rising number of homeless persons. This has resulted in a new category of the homeless population—the working poor. Congress must work with the States to ensure that a sufficient amount of low-income housing is available to meet the needs of the population. Although the passage of NAHA 1990 addressed many of the Nation's housing needs, much more remains to be done to make up for the drastic decrease in funding that housing programs experienced throughout the 1980's.

The Stewart B. McKinney Homeless Assistance Act Amendments of 1990 provided a modest increase in authorization levels and some redefinition and expansion of services. A key issue of debate in both the McKinney Act and NAHA was the provision of social services within the context of public housing. Although the concept of supportive services was included in both bills, no fiscal year 1991 appropriations were made for these new social service programs. Congress has recognized the need for supportive services by incorporating language into legislation, but they must now work to ensure that these programs receive adequate appropriations in fiscal year 1992.

Homelessness will continue to increase unless significant attention is paid to the shortage of adequate housing, social services programs are initiated, and the issue of noninstitutionalization is addressed. Congress made moderate strides in improving homeless assistance in 1990, but even more must be done in the future. Congress must make homelessness a priority in order to improve the current situation.

Chapter 12

ENERGY ASSISTANCE AND WEATHERIZATION

OVERVIEW

Two Federal programs exist to ease the energy cost burden on low-income individuals. They are the Low-Income Home Energy Assistance Program (LIHEAP) and the Department of Energy's (DOE) weatherization assistance program.

Although these programs have played an important role in helping millions of America's poor pay for energy and to weatherize their homes, there is a dramatic gap between existing Federal resources and the needs of the population these programs are intended to serve. Funding for these programs was slashed between the mid-1980's through 1989, but in subsequent fiscal years has leveled off.

In fiscal year 1990, LIHEAP provided heating and energy crisis assistance to an estimated 6 million low-income American households, up slightly from 5.9 million in fiscal year 1989. These households represent less than 25 percent of all households with incomes under the Federal maximum standard for the program (150 percent of poverty or 60 percent of State median income) and no more than 35 percent of all households with incomes under the stricter income standards adopted by most States, which range from 110 percent of poverty to the Federal maximum standard.

The Reagan administration pushed to substantially cut LIHEAP and to eliminate the DOE weatherization program. Between 1985 and 1989, Congress cut appropriations for LIHEAP by $717 million or 34 percent. States responded differently to these cuts. For example, a survey of 45 LIHEAP State program administrators indicate that, for fiscal year 1988, 22 States cut heating benefits, 13 reduced the number of households served, and 18 eliminated or reduced the use of LIHEAP funds for weatherization. Twenty-six States used oil overcharge funds to supplement LIHEAP appropriations, but the majority of these still had to reduce program services. During this same period, 1985 through 1989, the DOE's weatherization assistance program was cut by 20 percent.

Although Congress views these programs as the Federal Government's major effort to assist low-income households with their energy costs, the perception prevailed during this period that the States had substantial oil price overcharge funds available to use for funding LIHEAP. At the same time, the States transferred LIHEAP funds to other block grant programs. In addition, the programs were reduced twice under the Gramm-Rudman-Hollings Act, in 1986 and 1989. All of these factors, combined with the Reagan administration's efforts, resulted in deep cuts in funding for these programs in the second half of the 1980's. Since that time, despite Bush administration attempts, Congress has refused to further reduce program funding in these areas.

A. BACKGROUND

The radical changes in world oil markets following the 1973 embargo triggered profound changes in the household budgets of Americans. Over the following decade, the proportion of income required to purchase energy rose sharply, simultaneously driving up the costs of producing many other essential items. These higher energy costs had a harsh impact on the elderly poor.

According to DOE data for fiscal year 1989, LIHEAP households spent $1,009 or 14 percent of their income on residential energy, as compared to $1,110 or 3 percent of total income for households of all income levels. All low-income households (annual incomes under 150 percent of the poverty line or 60 percent of the State's median income) spent $973, or 11 percent of their income, on their residential energy needs.

The high cost of energy is a special problem for the low-income elderly because they are particularly susceptible to hypothermia—the potentially lethal lowering of body temperature. The Center for Environmental Physiology in Washington, D.C., has reported that experts estimate that hypothermia may be the cause of death for up to 25,000 elderly people each year. The Center reports that most of these deaths occur after exposure to cool indoor temperatures rather than extreme cold. In addition, the situation can worsen many pre-existing conditions and diseases in older adults, such as arthritis. Although another disease may ultimately be listed as the cause of death, the Center maintains that many deaths are causally related to hypothermia.

1. The Low-Income Home Energy Assistance Program

Preceding the establishment of LIHEAP were a series of more modest, short-term crisis intervention programs in the 1970's. These programs were administered by the Community Services Administration (CSA) on an annual budget of approximately $200 million. However, between 1979 and 1980 the price of home heating oil doubled. As a result, Congress expanded aid for energy sharply by creating a three-part, $1.6 billion energy assistance program. Of this amount, $400 million went to CSA for the continuation of its crisis-intervention programs; $400 million to the Department of Health and Human Services (HHS) for one-time payments to recipients of Supplemental Security Income (SSI); and $800 million to HHS for distribution as grants to States to provide supplemental energy allowances.

In 1980, Congress passed the Home Energy Assistance Act as part of the crude oil windfall profit tax legislation, appropriating $1.85 billion for the program. At present, LIHEAP is authorized by the Low-Income Home Energy Assistance Act (Title XXVI of the Omnibus Budget Reconciliation Act of 1981) as amended by the Human Services Reauthorization Acts of 1984, 1986, and 1990. Appropriations for fiscal year 1991 of $1.450 billion have been cut sharply from the $2.1 billion appropriated for the peak fiscal years

1985 and 1986. Appropriations in fiscal years 1988, 1989, and 1990 were $1.535 billion, $1.383 billion, and $1.393 billion, respectively. In recognition of the economic impact of the Iraqi invasion of oil-producing Kuwait, the 1991 appropriation bill also included $200 million contingency fund should energy prices rise by 20 percent or more.

Under LIHEAP, block grants are made to the States, the District of Columbia, approximately 114 Indian tribes and tribal organizations and 6 U.S. territories, allocated by formulas based largely on home energy expenditures by low-income households. Financial assistance is provided to eligible households, usually directly or through vendors, for home heating and cooling costs, energy-related crisis intervention aid, and low-cost weatherization. Some States also make payments in other ways, such as through vouchers or direct payments to landlords.

States also are allowed some flexibility in the use of their grants—up to 10 percent may be transferred into other block grant programs, up to 15 percent may be used for weatherization programs, and up to 15 percent may be carried over to the next fiscal year. No more than 10 percent of the grant may be used for administrative costs. In the 1990 reauthorization of LIHEAP some of this flexibility was reduced, as discussed in the legislation section of this chapter.

States establish their own benefit structures and eligibility rules within broad Federal guidelines. Eligibility may be granted to households receiving other forms of public assistance, such as SSI, Aid to Families with Dependent Children (AFDC), food stamps, certain need-tested veterans' and survivors' payments, or those households with incomes of less than 150 percent of the Federal poverty income guidelines or 60 percent of the State's median income, whichever is greater. Lower income eligibility requirements may be set by States and other jurisdictions, but not below 110 percent of the Federal poverty level.

According to HHS, States provided heating assistance to 5.7 million households in fiscal year 1990. About 1 million households received energy crisis assistance, primarily for winter crisis assistance rather than for summer crisis assistance. Based on previous State estimates, HHS calculates that about two-thirds of the households reported receiving winter crisis assistance also received regular heating assistance. This would make the unduplicated number of households receiving assistance with heating costs to be about 6 million. This compares to the 5.9 million households assisted in fiscal year 1989. In addition, 200,000 households received weatherization assistance in 1990 and 300,000 households received cooling assistance.

The elderly comprise the single largest group of recipients in the LIHEAP. In fiscal year 1989, 35 percent of those who received heating assistance and 51 percent of those who received cooling assistance were elderly households. In the same year, 16 percent of those who received winter crisis aid and 34 percent of those receiving weatherization aid were elderly recipients.

According to the HHS report to Congress for fiscal year 1989, the LIHEAP benefit for heating assistance ranged from $51 to $473, averaging $182. This offset about 52 percent of the average fiscal year 1989 heating costs for recipients. Average fiscal year 1989 home heating costs for all recipient households were about $395. On average, according to HHS, households receiving LIHEAP benefits have higher heating costs and lower income than low-income, nonrecipient households.

HHS cannot estimate precisely the number of households eligible for LIHEAP. Typically, States operate LIHEAP for only part of the year. Also, there is no data source that can provide seasonal national information on income and participation in other programs that provide categorical eligibility for LIHEAP. Further, States' procedures for determining eligibility may annualize 1 or more month's income to test against the income standard the State has adopted. Thus, households may be eligible for LIHEAP even though their actual annual income is above the income maximum set by law.

Notwithstanding these limitations, based on the March 1989 Current Population Survery, HHS estimates that an estimated 25.2 million households had incomes under the Federal maximum standard, and that 17.4 million households had incomes under the more stringent income eligibility standards adopted by many of the States.

2. THE DEPARTMENT OF ENERGY WEATHERIZATION ASSISTANCE PROGRAM

The DOE weatherization assistance program was originally authorized under the Energy Conservation and Production Act of 1976. The program is designed to reduce heating and cooling costs in homes of low-income households. Although the Reagan and, more recently, the Bush administrations proposed to eliminate the program, Congress has continued to fund the program.

The program began under the Emergency Energy Services Conservation Program of 1975 to provide relief to needy households by increasing energy efficiency through insulation and repairs. By 1985, it had grown to a $191 million program. Beginning in the following year, however, appropriations were reduced, and the trend continued until the fiscal year 1991. In fiscal years 1987 through 1990, the program operated at a level of $161 million. The fiscal year 1991 appropriation increased to $198 million.

Through the program, funds are made available to States, which in turn allocate dollars to nonprofit agencies for purchasing and installing energy conserving materials, such as insulation, and for making energy-related repairs. Federal law allows a maximum average expenditure of $1,648 per household, unless a state-of-the-art energy audit shows that additional work on heating systems or cooling equipment would be cost-effective.

The stated goals of the weatherization program include: improved energy efficiency in the homes of participants; reduced fuel bills for participants; reduced national energy consumption; and increased employment opportunities from the installing and manufacturing of low-cost weatherization materials. In 1990, legislation reauthorizing the program also permits and encourages the use of innovative energy saving technologies to achieve these goals.

To be eligible for weatherization assistance, household income must be at or below 125 percent of the Federal poverty level. States, however, may raise their income eligibility level to 150 percent of the poverty level to conform to the LIHEAP income ceiling. States may not, however, set it below 125 percent of the poverty level. Households with persons receiving AFDC, SSI, or local cash assistance payments are also eligible for assistance. Priority for assistance is given to households with an elderly individual, age 60 and older, or a handicapped person.

Since its inception through 1988 the weatherization program has served more than 1.8 million homes. In 89,966 of these homes, at least one resident was age 60 or older. In fiscal years 1987 and 1988, 107,045 and 115,120 homes were weatherized, respectively. In fiscal year 1989, an estimated 89,000 homes were modified under the program, with one-third of the residents estimated to be age 65 or older.

As part of a comprehensive DOE study of the program, the agency is examining types of occupant behavior that contribute to energy savings, as well as combinations of weatherization materials that optimize energy savings. A client education program relating to energy conservation behavior is also in progress. The study is expected to be completed in 1993.

B. ISSUES

1. Evaluating Energy Assistance and Savings

Elderly persons are particularly at risk to both hypothermia and heat stress. Hypothermia can set in at indoor temperatures between 50 and 60 degrees Fahrenheit. Diseases or weakness of the heart and blood vessels, conditions that are common among the elderly, contribute to the incidence of heat stress, which in turn can trigger heat exhaustion, heatstroke, heart failure, and stroke.

Both LIHEAP and the weatherization assistance program give priority to elderly and handicapped citizens to assure that these households are aware that help is available, and to minimize the danger of a shutoff of utility services. According to HHS, about 37 percent of households receiving assistance with heating costs had at least one elderly member age 60 or over.

Although States have come up with a variety of means for implementing the targeting requirement, several aging organizations have suggested that Older Americans Act programs, especially senior centers, be used to disseminate information and perform outreach services for the energy assistance programs. Discussions with area agencies on aging and senior center staff indicate that increased effort has been made in recent years to identify elderly persons eligible for energy assistance, and to provide the elderly population with information about the risks of hypothermia.

A 1986 study of 13 States, which accounted for 46 percent of the fiscal year 1985 LIHEAP appropriation and 49 percent of the Nation's low-income households, cited that all of these States reported using local organizations and aging agencies for outreach to the elderly and eligible households.

According to a 1986 report prepared by the Economic Opportunity Research Institute for the National Association of State Community Services Programs, frail or disabled elderly people, the very poor, and households with a history of energy shutoffs are in greater need of assistance than many households that receive energy aid. It was estimated that about 2.8 million such households, with average incomes of $2,196, are not served. Households that receive aid under LIHEAP, on average, have higher incomes and lower energy costs than eligible households not receiving the aid. The report stated that meeting the needs of those not currently being served under LIHEAP requires more money. Using 1984 average benefits, achieving a 55-percent participation rate would require a 23-percent increase in LIHEAP funding.

According to the HHS report for fiscal year 1989, low-income households expend a greater proportion of their income for space heating than do other households. The percentage of income for heating is greater still for LIHEAP recipient households. The average annual income of LIHEAP recipient households is 15 percent lower than the average annual income of other low-income households. Nationally, fiscal year 1989 heating costs represented about 4 percent of the average income for low-income households and 5 percent of the average income for LIHEAP recipient households, compared to about 1 percent of income for the average U.S. household.

The National Low Income Energy Consortium (NLIEC) issued a report in October 1988, entitled "The Late Great Energy Crisis: Hidden Hardships" which analyzed data from government and private sources. It concludes that for many Americans, "who are disproportionately poor, elderly and infirm, energy remains as critical a concern today as it did to every American in the most ominous days of the oil embargo." The report estimated that, in the mid-eighties almost one-fourth of poverty or near-poverty households spent more than 25 percent of their income on residential fuel expenditures. During the winter of 1986–87, the report stated that over 28 percent of all poor or near-poor households suffered without heat for 1 or more days because their utility or fuel bill was not paid.

Also, according to the NLIEC report, in 42 States, 30 percent of an elderly person's SSI benefits were consumed by home energy costs during the coldest months of the 1983–84 winter. In nine States, home energy costs totaled 50 or more percent of SSI benefits.

LIHEAP, however, has its critics, who generally take one of two positions. Some argue that the public welfare system, excluding LIHEAP, already is either sufficient or too generous. Another view is that assistance is needed, but not in the form provided by LIHEAP.

Those who oppose specific energy aid for low-income individuals contend that when combined with other welfare benefits, the LIHEAP increases the disincentive to work, unnecessarily increases the Federal deficit, and makes the benefits under welfare programs too generous, especially because LIHEAP benefits are not counted as income for determining eligibility and benefit levels under other means-tested assistance programs. It is also argued that LIHEAP was intended to be only a temporary emergency measure, designed to help households cope with the energy price shocks of the 1970's, and should not become part of the permanent public welfare system

Others may favor energy-related aid for those with low incomes, but maintain that assistance could be provided more efficiently through the more established means-tested programs, such as AFCD, SSI, or food stamps. However, this would exclude the currently estimated 30 percent of LIHEAP recipients who are nonwelfare poor, such as the elderly and working poor.

Others argue that LIHEAP, by increasing household income available for energy, discourages energy conservation. The twin goals of helping low-income households meet high energy costs and encouraging energy conservation would be better achieved, some assert, through home weatherization or renewable energy home improvements.

Various studies have attempted to quantify energy savings from Federal weatherization efforts. According to the GAO, it is difficult to measure such savings due to differing housing conditions, climatic conditions, and fuel prices throughout the country. Additionally, little or no effort has been made to verify the accuracy of fuel-use records in homes that have been weatherized. Experts in this area have noted that most studies do not use control groups to compare fuel costs in weatherized homes to fuel costs in homes not weatherized. Lacking a control group, it is difficult to accurately predict whether changes in energy consumptions are due entirely to weatherization assistance or to changes in fuel prices, conservation programs, appeals from political leaders, or a combination of these. Further, it has been observed by program personnel that some households may conserve less after weatherization because they raise their thermostats to a more comfortable level.

According to GAO, the extent to which DOE's program is reducing energy costs and consumption is unknown by DOE and the States that administer the DOE program. While DOE has asserted 20- to 25-percent annual energy savings in homes weatherized through its program, GAO reports that this claim has questionable reliability because of DOE's sampling and data problems.[1]

A study conducted by the State of Minnesota on its weatherization program employed a more scientific methodology to evaluate energy savings. Based on an analysis of fuel records from both weatherized and nonweatherized homes, the study concluded that the DOE program was successful in reducing energy consumption by an average of 13 percent. The study also concluded that the cost of weatherization is likely to be repaid within 3½ years through lower fuel bills.[2]

The GAO reported, however, that the Minnesota study was too geographically limited to reveal savings on a nationwide basis. In response, GAO concluded that there is no nationwide study on cost savings that incorporates standardized statistical methods in a way to assure maximum reliability. However, the evaluation discussed earlier in this chapter (under the DOE weatherization program description) was conducted after GAO's analysis, and provides evidence that the program is effective. A number of States have also conducted studies since that time and many show energy savings in the 14 to 25 percent range.

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[1] U.S. Government Accounting Office. Uncertain Quality, Energy, Savings and Future Production Hamper the Weatherization Program; Report to the Congress by the Comptroller General of the United States. EMB 82-2. October 26, 1982. Washington, 1982. pp. 18-20.

[2] Hirst, Eric and Raj Talwar. "Reducing Energy Consumption in Low-Income Homes." Evaluation of the Weatherization Program in Minnesota. Evaluation Review, V. 5, October 1981. pp. 671-683.

C. CONGRESSIONAL RESPONSE

In response to continued efforts by the Reagan administration to reduce Federal funding for LIHEAP and to eliminate or phase-out the DOE weatherization program, Congress grudgingly reduced appropriation levels. Particularly in the mid-eighties through 1989, funding for these two programs fell sharply. Since that time, despite similar attempts by the Bush administration, program funding has stabilized.

1. Low-Income Home Energy Assistance Program

(A) LIHEAP REAUTHORIZATION

On November 3, 1990, the Augustus F. Hawkins Human Services Reauthorization Act, which included legislation reauthorizing the LIHEAP, was signed into law as Public Law 101-501. During the reauthorization process, the Bush administration did not propose substantive changes to the program.

The 1990 amendments reauthorized appropriations through fiscal year 1994 at $2.150 billion and $2.230 billion for fiscal years 1991 and 1992, respectively, and for such sums as may be necessary for the following two fiscal years.

Breaking with the past, the new law provides that the States' authority to transfer a portion of LIHEAP funds—namely, 10 percent—will cease beginning in fiscal year 1994. Until that time, States may continue to shift up to this percentage of their LIHEAP allotment to other social programs.

In addition, States may apply for a waiver to use up to 25 percent of their LIHEAP allotment for home repairs for low-income persons.

(B) LIHEAP APPROPRIATIONS

The fiscal year 1991 appropriation is $1.450 billion, a level far below the $2.1 billion provided to the program during its peak fiscal years of 1985 and 1986. In addition, Congress established a $200 million contingency fund should conflicts in the Persian Gulf drive energy prices up by 20 percent or more. In the previous fiscal year, the LIHEAP appropriation was $1.443 billion, including a $50 million supplemental.

In setting appropriations, the main issue in the past has been the extent to which States have access to "oil price overcharge" money to help fund LIHEAP.

From 1973 to 1981, the United States imposed price controls on crude oil and petroleum products in response to the Arab oil embargo. Since then, a number of lawsuits have been filed against certain oil companies for alleged overcharges during that period.

Money recovered from oil companies, the result of several court decisions under the Emergency Petroleum Allocation Act of 1973 (P.L. 93-159), has been made available to the States as possible additional funding for LIHEAP and other energy-related programs. The courts stipulated a restitutionary principle originally adopted by Congress, which requires that these funds be used to "supplement, not supplant" existing Federal and States resources. Each state decides how it will allocate the funds.

Since 1981, more than $3.7 billion has been provided to the States in recouped funds, and nearly all of it was distributed between 1986 and 1988. According to a November 1988, report by The National Consumer Law Center, the States have allocated 93 percent of total funds received. Of the combined funds, only 20 percent was designated for LIHEAP. The remaining funds were allocated among other low-income programs and DOE's weatherization program. Most States decided to allocate the spending of the overcharge funds over a number of years.

Data from HHS and a January 1991 GAO report indicate that appropriation cuts were clearly not supplanted by oil overcharge funds. Since the beginning of oil price overcharge distributions to the States, HHS estimates that over $700 million has been designated by the States for support of LIHEAP. Telephone survey estimates by HHS indicate the States used about $170 million of oil overcharge money for LIHEAP in fiscal year 1990.

Although approximately $100 to $200 million per year in additional oil overcharge funds are expected over the next 4 to 6 years, their availability is no longer a major issue in deciding on funding levels for LIHEAP. For example, the Bush administration's fiscal year 1992 budget proposal stressed the size of the Federal budget deficit in its push for program cuts.

2. Weatherization

As in the past, the Bush administration proposed eliminating the DOE's weatherization assistance program in its fiscal year 1991 budget. The proposed elimination reflected the administration's view that weatherization efforts should be supported by the private sector. Ignoring the administration's recommendation, Congress appropriated $198 million for the program in fiscal year 1991.

Prior to 1990, the weatherization program had been repeatedly funded without an appropriations authorization. On October 18, 1990, however, Congress reauthorized the weatherization program. The legislation was enacted as part of the State Energy Efficiency Programs Improvement Act (P.L. 101-440). Under the new law, $200 million was authorized to be appropriated in fiscal year 1991, while such sums as may be necessary are authorized in the following three fiscal years.

By giving States more flexibility on spending limitations, the new law also encourages them to use more sophisticated auditing techniques and heating system modifications. In addition, the law authorizes a weatherization incentive fund of $20 million to reward States that attract more non-Federal funding.

3. Prognosis

There is little doubt that LIHEAP has been successful in providing emergency energy relief to millions of poor Americans, a significant percentage of whom are elderly. At the same time, DOE's weatherization program has reduced the energy expenditures for many persons living in poverty. Nevertheless, the debate over funding levels for, if not the merits of, these programs will likely persist.

In his fiscal year 1992 budget, President Bush proposed to cut LIHEAP by 36 percent, from $1.6 billion (including a $200 million contingency fund) to $1.025 billion. Under the proposal, an additional $100 million would be available to the program if fuel prices did not decline. The stated justification for the proposed cut is the size of the Federal budget deficit. In addition, the budget also asserts that LIHEAP was never intended to meet the entire home energy needs of the poor, but was rather intended to supplement energy assistance from other sources. Finally, the administration names LIHEAP among the programs to be included in a proposed mega-block grant program. In the coming months, the Congress can be expected to debate the validity of these proposals. Also influencing the outcome of this debate will be the impact of the Persian Gulf war on energy prices.

With respect to DOE's weatherization program, the President proposes no appropriation be made for this account in the coming fiscal year. Rather, $28 million in oil-overcharge funds would be used to run the program in fiscal year 1992 under the proposal. This contrasts with the current fiscal year 1991 funding level of $198 million, of which $26 million is derived from oil-overcharge funds.

Although the fiscal year 1992 funding level for LIHEAP and the weatherization program is unknown, it is certain that millions of poor will continue to be underserved.

Chapter 13

OLDER AMERICANS ACT

OVERVIEW

For the past 25 years, the Older Americans Act (OAA) has provided a wide array of community services to older persons. The OAA was created during a time of rising societal concern for the needs of the poor. Its enactment marked the beginning of a variety of programs specifically designed to meet the social and human needs of the elderly. The OAA was one in a series of Federal initiatives that were part of President Johnson's Great Society programs. These legislative initiatives grew out of a concern for the large percentage of older Americans who were impoverished, and a belief that greater Federal involvement was needed beyond the existing health and income-transfer programs. Although older persons could receive services under other Federal programs, the OAA was the first major legislation to organize and deliver community-based social services to older persons.

The Older Americans Act followed similar social service programs initiated under the Economic Opportunity Act of 1964. The OAA's conceptual framework was similar to that embodied in the Economic Opportunity Act and was established on the premise that decentralization of authority and the use of local control over policy and program decisions would create a more responsive service system at the community level.

When enacted in 1965, the Older Americans Act established a series of broad policy objectives designed to meet the needs of older persons. Although the OAA then lacked both legislative authority and adequate funding, it did establish a structure through which the Congress would later expand aging services.

Over the years, the essential mission of the Older Americans Act has remained very much the same: to foster maximum independence by providing a wide array of social and community services to those older persons in the greatest economic and social need. The key philosophy of the program has been to help maintain and support older persons in their homes and communities to avoid unnecessary and costly institutionalization. Services supported under the OAA include congregate and home-delivered meals, senior centers and nursing home ombudsman activities, and community service employment programs.

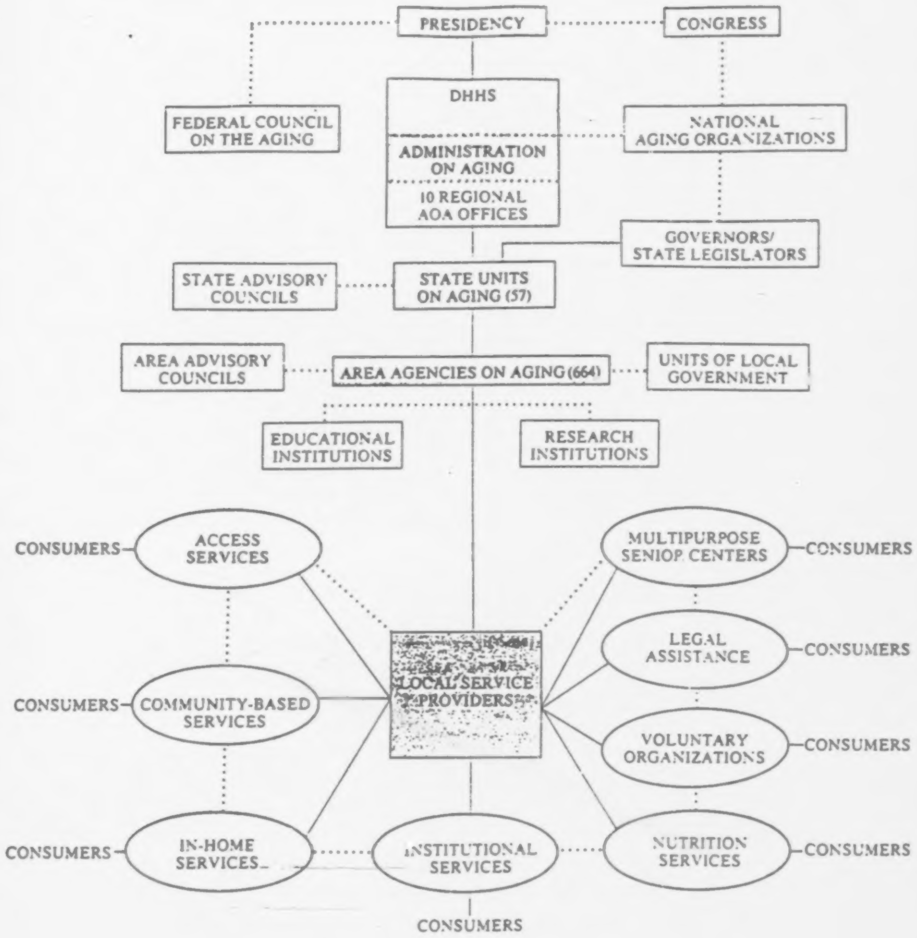
Funding for the Older Americans Act grew slowly during the 1960's. During the 1970's, Congress significantly improved the OAA by broadening its scope of operations and establishing the foundation for a "network" on aging under the Title III program umbrella. In 1972, a national nutrition program for older Americans was created. One year later, area agencies on aging (AAAs) were authorized. AAAs, in conjunction with State units on aging (SUAs), provide the administrative structure for programs under the OAA. In addition to funding specific services, these entities act as advocates on behalf of older persons and help to develop a service system that will best meet older Americans' needs. As originally conceived by the Congress, this system was meant to encompass both services funded under the OAA, and services supported by other Federal, State, and local programs. The purpose of the community service employment program is to subsidize part-time community service jobs for unemployed persons aged 55 and over who have low incomes. The program, for example, administered by the Department of Labor, awards funds to national organizations and to State agencies to operate the program.

In fiscal years 1978 and 1981 funding levels for OAA programs were increased. This allowed for the further development of AAAs and for the provisions of other services, including access (transportation, outreach, and information and referral), in-home and legal services.

Expansion of OAA programs continued until the early 1980's when, in response to the Reagan administration's policies to cut the size and scope of many Federal programs, the growth of OAA spending was slowed substantially, and for some programs was reversed. For example, between fiscal years 1981 and 1982, Title IV funding for training, research, and discretionary programs in aging was cut by approximately 50 percent. However, widespread congressional support for other OAA programs, especially nutrition and senior employment, served to protect them. This broad congressional support for OAA programs continued during the 1987 reauthorization of the OAA and can be expected to continue in the future, including the 1991 reauthorization.

Chart 1

OLDER AMERICANS ACT NETWORK


PRESIDENCY
CONGRESS
DHHS
ADMINISTRATION ON AGING
10 REGIONAL AOA OFFICES
FEDERAL COUNCIL ON THE AGING
NATIONAL AGING ORGANIZATIONS
GOVERNORS/ STATE LEGISLATORS
STATE ADVISORY COUNCILS
STATE UNITS ON AGING (57)
AREA ADVISORY COUNCILS
AREA AGENCIES ON AGING (664)
UNITS OF LOCAL GOVERNMENT
EDUCATIONAL INSTITUTIONS
RESEARCH INSTITUTIONS
CONSUMERS
ACCESS SERVICES
MULTIPURPOSE SENIOR CENTERS
CONSUMERS
LOCAL SERVICE PROVIDERS
LEGAL ASSISTANCE
CONSUMERS
CONSUMERS
COMMUNITY-BASED SERVICES
VOLUNTARY ORGANIZATIONS
CONSUMERS
CONSUMERS
IN-HOME SERVICES
INSTITUTIONAL SERVICES
NUTRITION SERVICES
CONSUMERS
CONSUMERS

SOURCE: National Association of State Units on Aging

A. THE OLDER AMERICANS ACT TITLES

The following is a brief description of each title of the Older Americans Act of 1965, as amended.

1. TITLE I—DECLARATION OF OBJECTIVES

Title I outlines broad social policy objectives aimed at improving the lives of all older Americans in a variety of areas including income, health, housing, long-term care, and transportation.

2. TITLE II—ADMINISTRATION ON AGING

Title II establishes the Administration on Aging (AoA) to administer most OAA programs and to act as the chief Federal agency advocate for older persons. It also authorizes the Federal Council on Aging to advise the President and Congress regarding the needs of older persons.

The organizational status of the AoA has been a recurring issue during previous OAA reauthorizations due to a concern that because AoA is located within the Office of Human Development Services, it does not have the visibility necessary to be an effective advocate for the elderly. The 1987 amendments addressed this concern by elevating the status of the Commissioner within the Department of Health and Human Services. The law now requires the Commissioner to report directly to the Secretary. Prior law required the Commissioner to report to the "Office of the Secretary."

The law also required the Commissioner to establish within AoA a new Office for American Indian, Alaskan Native, and Native Hawaiian Programs to be headed by an Associate Commissioner. In addition, the amendments added a number of new provisions requiring AoA to increase its data collection efforts. Finally, the amendments increased from six to nine the number of older persons who serve on the Federal Council on Aging and require the Council to have representation from Indian tribes.

3. TITLE III—GRANTS FOR STATE AND COMMUNITY PROGRAMS ON AGING

Title III establishes authority for the network of State and area agencies on aging and requires the development of a comprehensive and coordinated services system for older persons.

Title III originally contained three parts authorizing funds to State agencies on aging for supportive services (Part B), congregate nutirition services (Part C–1), and home-delivered nutrition services (Part C–2). The 1987 OAA amendments made certain changes relating to the administration of these services by State and area agencies on aging and included a number of new funding authorizations for additional programs including: Nonmedical in-home services for the frail elderly under a new Part D; services to meet the special needs of the elderly under a new Part E; health education and promotion activities under a new Part F; elder abuse prevention activities under a new Part G; long-term care ombudsman services; and outreach services to older persons potentially eligible for Supplemental Security Income, Medicaid, and food stamp programs.

While State and area agencies have had responsibilities in these areas under prior law, separate authorizations of Title III funds were not specified. Except for in-home services for the frail elderly, the amendments prohibited appropriations of funds for the new authorizations unless total appropriations for programs in effect in fiscal year 1987 increased by at least 5 percent. These funding restrictions remained in effect through fiscal year 1990.

State agencies set a minimum percentage of funds to be used by each area agency on aging for the three categories considered as priorities under the area plan. These are: (1) access services (transportation, outreach and information, and referral), (2) in-home services (homemaker and home health aide, visiting and telephone reassurance, chore maintenance, and supportive for families of elderly victims of Alzheimer's and related diseases), and (3) legal assistance.

Several provisions require the coordination of Title III services on behalf of specific groups of older individuals. Various provisions focus on the needs of persons with mental illness, victims of Alzheimer's disease and their families, persons with disabilities, and those in need of community-based long-term care services.

Other Title III provisions require State and area agencies on aging to focus on the needs of older Indians, and require that the distribution of this group be considered when planning services with the State and the planning and service area. In addition, the law requires area agencies to conduct outreach activities to identify older Indians and inform them of services under the OAA if their population is significnat within the planning and service area.

4. TITLE IV—TRAINING, RESEARCH AND DISCRETIONARY PROJECTS AND PROGRAMS

The Title IV programs authorize the Commissioner to award funds for a broad array of training, research, and demonstration programs in the field of aging.

Demonstration programs provide information related to health education and promotion, volunteerism, coordination of the long-term care ombudsman program with protection and advocacy systems for the disabled, and consumer protection activities in long-term care. For the latter two, separate funding amounts were authorized distinct from the overall Title IV funding. Title IV also funding of long-term care gerontology centers mandates.

5. TITLE V—COMMUNITY SERVICE EMPLOYMENT FOR OLDER AMERICANS

The Community Service Employment Program authorizes funds to subsidize part-time community service jobs for unemployed, low-income persons 55 years of age or older. Funds have been awarded to 10 national organizations and to State agencies. Enrollees are paid at the Federal or State minimum wage or the local prevailing rate of pay for similar employment.

The allowable administrative cap for the program is set at 13.5 percent, but the Secretary of Labor may raise the cap to 15 percent. Title V wages are not considered when determining eligibility for Federal housing and food stamp programs. In addition, the Secretary of Labor and Title V grantees are required to distribute information to help program participants identify age discrimination and understand their rights under the Age Discrimination in Employment Act. Finally, some Title V funds are reserved for national Indian aging organizations and national Pacific Island and Asian American aging organizations.

6. Title VI—Grants for Native Americans

Title VI authorizes funds for supportive and nutrition services for older Indians, under Part A, and for older Native Hawaiian organizations under Part B.

Under Part A, a tribal organization is eligible for Title VI funds if it has at least 50 older Indians. The law allows older Indians to receive assistance under Title VI, as well as under Title III programs.

Part B, the Native Hawaiian Program, retains a separate authorization under Title VI. Like tribal organizations, the Native Hawaiian organizations are eligible for funds if they represent at least 50 Native Hawaiians who are 60 years of age or older.

7. Additional Provisions

1991 WHITE HOUSE CONFERENCE ON AGING

The 1987 amendments authorized the President to call a White House Conference on Aging in 1991—(a) to increase awareness of the contributions of older individuals to society, (b) to identify problems as well as the well-being of older individuals, (c) to develop recommendations for the coordination of Federal policy with State and local needs, (d) to propose specific and comprehensive recommendations for both executive and legislative action to maintain and improve the well-being of older individuals, and (e) to review the status of recommendations adopted at previous White House Conferences on Aging.

The conference is intended to bring together representatives of Federal, State, and local governments, persons working in the field of aging, and the general public, particularly older persons. The 1987 amendments also set forth requirements regarding delegate selection, committee composition, conference agenda, and reporting requirements.

Congress has appropriated $1 million for the 1990 White House Conference. Aging advocates are anxiously awaiting word from the White House as to when the conference will be called.

B. ISSUES

1. Cost-Sharing

During the 1987 reauthorization hearings, the administration's proposal included a provision that would have authorized States, at their option, to permit area agencies on aging to charge fees, based on beneficiaries' ability to pay, for supportive services under Part B of Title III. Under this proposal, States could choose which supportive services would be subject to charges.

Organizations representing State and area agencies on aging submitted their own proposal to allow State agencies on aging to establish procedures for either voluntary or mandatory cost-sharing for selected services under Title III, and to allow area agencies on aging to solicit voluntary contributions. Agencies at the State and local levels are increasingly pressed to find alternative sources of funding to supplement the limited availability of Federal funding and to continue to provide needed services. In advocating the cost-sharing proposal, the State and area agencies believed that a sliding fee scale would allow coordination of OAA program services with other services that are means-tested. They argued that cost-sharing would increase the level of services without increasing Federal funding, and could be structured to increase services to those most in need, thus increasing low-income and minority participation in Title III programs. Some services, such as referral, outreach, advocacy, and ombudsman services, were to be exempt, as well as those persons with incomes less than 125 percent of the poverty level.

This latter proposal, which drew sharp opposition, later was amended to allow a limited number of States to be given authority to conduct studies on cost-sharing in the programs in the OAA. Cost-sharing or fee-for-service, however, was viewed by many in Congress as either a preliminary step to or a pseudonym for means-testing. There continues to be concern that cost-sharing would produce an unintended opposite effect, causing participation of the neediest individuals to decline due to either a misunderstanding of the cost-sharing requirements or an unwillingness to disclose financial information.

Current law and regulation permit Title III programs to solicit voluntary contributions for services. Service providers are required to give older persons an opportunity to contribute to the cost of the service and to protect their privacy with respect to their contributions. Older persons, however, may not be denied a service if they are unable or unwilling to contribute toward the cost of the service.

Because the Older Americans Act was intended to be the major vehicle for the organization and delivery of community-based services to all older Americans regardless of income, Congress has consistently rejected any attempts to introduce means-testing. However, the Senate Committee on Labor and Human Resources requested the General Accounting Office to study current State cost-sharing systems. In October 1989, GAO issued a report on cost-sharing that found: (1) cost-sharing is used for in-home services in at least 36 States; (2) the services commonly subject to cost-sharing were adult day care, home health care, and personal services; (3) the majority of State and area agencies on aging that were surveyed by GAO supported cost-sharing, principally because it permitted them to serve greater numbers of clients and to offer a broader range of services; (4) self-reported income was the most commonly used determinant for establishing cost-sharing fees; and (5) cost-sharing fees, in the three States GAO examined closely, were generally a small percentage of client incomes and service costs.

Given the reality of limited funding, the issue of cost-sharing is sure to be raised for consideration during the 1991 reauthorization.

In late 1990, at the Commissioner on Aging's request, the Inspector General (IG) issued a report which assessed the cost-sharing experience of State programs for the elderly that provide in-home and adult day care services. The report found: (1) cost-sharing is considered fair and appropriate; (2) recipients were satisfied with the services provided and found them worth the cost; (3) money from cost-sharing programs helps States to expand programs and serve more recipients; and (4) cost-sharing programs operate efficiently. State officials surveyed recommend that any cost-sharing plan be carefully planned, flexible in its implementation, and provide a sliding fee scale for services based on recipients' self-declared disposable income.

In response to the IG report, the Commissioner on Aging recommended that the Department of Health and Human Services propose to Congress that the OAA be amended to permit States to use cost-sharing for Title III services, particularly Part B services provided to older persons with incomes of at least 200 percent above the poverty level.

2. TARGETING

Congress always intended that services provided under Title III of the Older Americans Act would be available to all older persons who need assistance, and that program participation would not depend on income status alone. However, successive amendments have suggested that nutrition and supportive services be focused on those persons in greatest social and economic need, and minorities.

How to improve targeting and outreach to certain subgroups of older persons, particularly low-income minority persons was a major issue during the 1987 reauthorization process. Although the OAA has required that State and area agencies on aging give preference to the elderly with the greatest economic or social need, especially low-income minority individuals, advocates stressed that all relevant sections of the OAA should specify this preference to emphasize the importance of serving those most in need.

The 1987 reauthorization hearings documented that participation by minorities in Title III programs had declined by a disturbing 27 percent since 1981. Reasons cited for the decline included that minority persons often felt that OAA programs were not responsive to their needs and priorities, meals were not culturally appropriate, non-English publications seldom were available, and there was insufficient publicity about OAA programs and referral services. Additional reasons given were that outreach to minority older persons by area agencies on aging was poor and that minorities were absent or excluded from the services delivery planning process.

Current law requires that each State and area plan identify those persons with greatest economic or social need, particularly low-income minority older persons, the State or planning and service area, and describe the methods used to meet this group's needs during the previous year. The law also includes provisions to ensure effective outreach to individuals in need, and requires evaluation of these outreach effects. Additional provisions ensure that service providers focus on the needs of low-income minority older persons and attempt to provide to these individuals services in at least the same proportion as they represent the total older population in the area.

A 1990 GAO report examined whether State formulas are considering the needs of elderly minorities when distributing Title III funds and whether they contain factors that are discriminating against minorities. The study found that 45 States use intrastate funding formulas to distribute Title III funds. States do not identify factors to be used for targeting despite the fact that the Administration on Aging's regulations require that formulas target those elderly in greatest economic or social need, particularly low-income minorities. The report also determined that AoA believes that the OAA does not authorize it to approve or disapprove formulas. Given AoA's position on the issue, the report recommends that Congress clarify whether AoA has authority to approve State formulas.

In addition, AARP released a study in 1990 examining the difficulty of obtaining accurate data on minority participation in Title III programs. Problems cited in the report include: (1) the difficulty in most States in reporting an unduplicated count of participants, the sole measure upon which minority participation is evaluated; (2) lack of consistent definitions of services provided and unclear mechanisms for classifying minority group members; and (3) the inability of the current data collection system to measure the level of services provided.

3. Public-Private Partnerships

In recent years State and area agencies have developed a variety of cooperative arrangements with private organizations with the aim of improving services for older persons. Functions performed by State and area agencies for private sector organizations include training of older workers, educating employees on the needs of and resources available to older persons, sponsoring conferences on aging, and developing materials and media on aging services. Some of these State and local activities have included employee elder care, defined as care provided by family members to their older relatives.

At the Federal level, the Administration on Aging in recent years has used some of its discretionary funds under Title IV of the Older Americans Act to encourage private sector initiatives. A significant ongoing project involves an award to the Washington Business Group on Health, a national membership organization representing about 200 local business and health coalitions. The purpose of this Title IV grant is to establish model partnerships between business communities and State and area agencies on aging to promote policies and programs to meet the needs of employed caregivers.

Clearly, some cooperative relationships between the aging network and the private sector fall within the goals and intent of the Older Americans Act. Two provisions under Title II of the OAA require the Administration on Aging to work with private sector organizations, including profitmaking organizations. Other sections of the law may be interpreted in a way that discourages efforts by the Title III State and area agency services network to develop contractual fee-for-service arrangements with private, for-profit organizations. Current law does not specifically address the extent to which State and area agencies may receive compensation as a result of a contractual arrangement with the private, for-profit sector, or to what extent such assistance can or should be done without charge. Initiatives in this direction, however, are rapidly emerging.

Recognizing a role for State and area agencies on aging to serve as providers of elder care benefits for private corporations, the Administration on Aging issued a program instruction to State and area agencies. Pursuant to this program instruction, States were asked to develop policies on workplace elder care and to submit these policies to the Commissioner by November 1990.

Concerns surrounding the issue of private sector involvement include: (1) the extent to which area agencies should be in the business of direct service provision; (2) whether contractual arrangements with private sector organizations can comport with the targeting requirements of the Older Americans Act; (3) how contractual arrangements with private sector organizations are to be viewed in the context of the OAA's prohibition on mandatory fees for services; and (4) how will State and area agencies' involvement in private sector initiatives impact on their current statutory responsibilities. These issues are sure to be raised during the 1991 reauthorization.

4. ORGANIZATIONAL STATUS OF THE ADMINISTRATION ON AGING

A recurring issue under the OAA has been the organizational status of the AoA. Even before the AoA was created as part of the OAA in 1965, the appropriate placement of an agency to oversee aging issues within the Federal framework was debated. The original sponsors of the legislation conceived of placing such an agency at the White House level so it would not be subordinate to any one agency or department; rather, it would be an independent agency able to carry out broad interdepartmental functions. This placement, however, was strongly opposed by officials of the executive branch. Therefore, the sponsors turned to a compromise position to expedite passage of the OAA. Under the 1965 legislation, AoA was placed within the then Department of Health, Education, and Welfare (HEW) and did not have independent status. However, over the years, many policymakers questioned whether AoA could carry out its interdepartmental functions and serve as a Federal coordinator and advocate for the elderly, as well as influence Federal programs and policies from its positions within a Federal department.

The 1973 amendments placed the AoA within the Office of the Secretary of HEW, made the Commissioner of AoA directly responsible to that office, and prohibited any delegation of the Commissioner's functions to any other officer not directly responsible to the Commissioner. When the Office of Human Development Services (OHDS) was subsequently created as part of the Office of the Secretary, AoA was placed as a separate unit within that office as part of an executive branch reorganization. During consideration of the 1978 amendments, discussion concerning the appropriate placement of AoA ranged from making it an independent office at the

White House level to retaining the agency in the current position. The amendments, however, did not change prior law, so the agency remained within OHDS.

Discussion about the proper placement of the Administration on Aging and the Commissioner on Aging recurred during the 1981 reauthorization process. However, despite consideration of the issue, Congress did not change AoA's status. Again in 1984, AoA's organizational placement was discussed. Although the House-passed reauthorization bill provided for an Office on Aging headed by a Commissioner on Aging who would report directly to the Secretary of HHS, the Conference agreement retained the pre-existing placement of AoA, but amended the law to emphasize a direct reporting relationship between the Commissioner and the Office of the Secretary of HHS.

In 1987, Congress further clarified the issue of the AoA's organizational status and reporting relationship with the Secretary by elevating the AoA to the same level of authority as assistant secretaries and other commissioners within the Department. Congress amended the law to require that the Commissioner report directly to the Secretary rather than to the Office of the Secretary.

Despite the improvements of the 1987 amendments, the push for elevating the status of the Commissioner to Assistant Secretary has gained momentum and is sure to be raised again during the 1991 reauthorization.

The organizational status of the Administration on Aging was addressed during an oversight hearing by the Senate Labor and Human Resources Aging Subcommittee on May 18, 1989. At that hearing, Kevin Moley, Assistant Secretary of Management and Budget of HHS, testified that the Commissioner on Aging reports directly to Secretary Sullivan "on programmatic and policy issues," although AoA continues to "receive administrative and logistical support from the Office of Human Development Services" within HHS.

Concerned about the lack of evaluative information on how effective AoA has been in meeting the objectives incorporated in the OAA, in 1990, Congress requested that the GAO conduct a study to examine: (1) the impact on minority elderly resulting from resources directed to them by AoA; (2) how AoA has provided technical assistance to and oversight of programs under the OAA through State and area agencies on aging; and (3) the extent to which the provision of services through AoA has been hampered by budgetary, organizational constraints, and administrative procedures applicable to AoA. The study is expected to be released sometime early in 1991.

C. CONGRESSIONAL RESPONSE

1. OLDER AMERICANS ACT AUTHORIZATION

The 1987 amendments to the Older Americans Act (P.L. 100-175) provided the following authorization levels from fiscal year 1988 through fiscal year 1991:

TABLE 1.—OLDER AMERICANS ACT AUTHORIZATION LEVELS, FISCAL YEAR 1988–91

[In thousands of dollars]

Act title	(As contained in P.L. 100–175)			
	1988	1989	1990	1991
TITLE II				
Federal Council on the Aging	$210	$221	$232	$243
TITLE III				
Grants for State and community programs on aging:				
Supportive services and centers	379,575	398,554	418,481	439,406
Nutrition services	645,130	684,837	727,778	773,017
Congregate	(414,750)	(435,488)	(457,262)	(480,125)
Home delivered	(79,380)	(83,349)	(87,516)	(91,892)
USDA commodities	[1] (151,000)	[1] (166,000)	[1] (183,000)	[1] (201,000)
In-home services for frail elderly	25,000	26,250	27,563	28,941
Assistance for special needs	[3] 25,000	[3] 25,000	([3] [4])	([3] [4])
Health education and promotion	[3] 5,000	([3] [4])	([3] [4])	([3] [4])
Elder abuse prevention	[3] 5,000	([3] [4])	([3] [4])	([3] [4])
Long-term care ombudsman	[3] 20,000	([3] [4])	([3] [4])	([3] [4])
Outreach for SSI, Medicaid, and food stamps	([2])	[3] 10,000	[3] 10,000	([4])
TITLE IV				
Training, research, and discretionary projects and programs	32,970	34,619	36,349	38,167
Home care demonstration projects	([2])	[3] 2,000	[3] 2,000	([2])
Ombudsman and advocacy demonstration projects	([2])	[3] 1,000		([2])
TITLE V				
Community service employment for older Americans	386,715	406,051	426,353	447,671
TITLE VI				
Grants for Native Americans	[5] 13,400	[5] 16,265	[5] 19,133	[5] 22,105
Part A—Indian Program	(12,100)	(14,900)	(17,700)	(20,600)
Part B—Native Hawaiian Program	(1,300)	(1,365)	(1,433)	(1,505)
TITLE VII				
Older Americans personal health education and training program	([6])	([6])	([6])	([6])
Total	[7] 1,538,000	[7] 1,604,797	[7] 1,667,889	[7] 1,749,550

[1] Public Law 100–175 requires the Secretary of Agriculture to maintain a reimbursement level of 56.76 cents per meal for FY 1986–91.

[2] Not authorized.

[3] The law requires that total appropriations for programs funded in FY 1987 increase by at least 5 percent over the previous year before appropriations for these new authorizations are made.

[4] Such sums as may be necessary.

[5] The law creates a separate Part B for funds for a Native Hawaiian program. As shown in the table, the law authorizes specific amounts for Part A, the Indian Program, and for Part B. The law further specifies that Part B receive funding only if the total appropriations for title VI exceed the FY 1987 funding level ($7.5 million). Part B will receive the first $250,000 of any appropriations exceeding the FY 1987 level, and half of any increase above the first $250,000 up to the authorized amount.

[6] This title is repealed.

[7] Plus such sums as may be necessary for certain programs.

Source: Congressional Research Service.

2. OLDER AMERICANS ACT APPROPRIATIONS

For fiscal year 1991, the Administration requested $1.2 billion for all programs authorized under the OAA. For most programs, the budget request was the same as amounts appropriated for fiscal year 1990. The following table provides a specific breakdown by major title areas:

TABLE 2.—OLDER AMERICANS ACT APPROPRIATIONS, FISCAL YEAR 1991

[In thousands of dollars]

Title II: Federal Council on the Aging	$181
Title III:	
Supportive services and senior centers	290,818
Ombudsman and elder abuse prevention	[1] 5,367
Nutrition services:	
Congregate	361,083
Home-delivered	87,831
USDA commodities	149,897
In-home services for frail elderly	6,831
Subtotal, Title III	860,501
Title IV: Training, research, and discretionary projects and programs	[2] 26,917
Title V: Community Service Employment	390,360
Title VI: Grants for Native Americans	14,639
Total	2,194,425

[1] Elder abuse prevention was not funded in fiscal year 1990.

[2] Includes $1 million for the unscheduled 1991 White House Conference on Aging.

3. CONGRESSIONAL HEARINGS AND ACTION

The Older Americans Act will be reviewed for reauthorization in 1991. In preparation for the 1991 reauthorization, the 101st Congress convened a number of hearings and legislative workshops to examine changes that may be necessary or desirable as part of the process.

On the House side, the Subcommittee on Human Services of the Select Committee on Aging conducted five hearings examining topics such as: (1) the 1987 Amendments as a foundation for aging policy in the 1990's; (2) meeting the needs of the frail elderly; (3) implementation of the 1987 Amendments; (4) public and private partnerships; and (4) whether the OAA has fulfilled its promise to expand the Nation's knowledge and understanding of aging.

On the Senate side, the Special Committee on Aging held a series of workshops which focused on a number of reauthorization issues, including: (1) information systems and information flow within the aging network; (2) legal assistance and the ombudsman program; and (3) the role of the Administration on Aging. In conducting this series of workshops, the Committee has taken the lead in experimenting with alternatives to the traditional hearing format. In conjunction with the workshop series, the Special Committee on Aging convened a series of informal working groups to further develop and define issues examined by the forums. In addition, during the latter part of the 101st Congress, the Committee met with various minority groups with particular interest in programs authorized under the OAA. These groups included Native Americans, African Americans, Asian Pacific Islanders, and Hispanics.

President Bush's continued delay in announcing plans for the 1991 White House Conference on Aging, authorized under the 1987 Amendments to the Older Americans Act, remains a matter of deep concern to aging advocates in Congress and across America. On June 26, 1989, the House Select Committee on Aging's Human Services Subcommittee held a hearing on the issue. In late 1989, Senator David Pryor, Chairman of the Senate Special Committee on Aging, initiated a letter signed by all members of the Committee, urging President Bush to promptly begin preparations for the 1991 conference. In the letter, the members suggested that providing long-term care services to all vulnerable populations, including disabled children and adults, would be an important topic for conference attendees to address. Despite continued pressure on the administration to call a White House Conference on Aging, at the close of 1990, no plans had been announced. Advocates remain concerned not only about how a conference can be planned for 1991, but also about the inadequate amount of money authorized ($1 million) for a conference, the cost of which exceeded $32 million in 1981.

D. PROGNOSIS

Fiscal year 1990 marked the 25th anniversary of the Older Americans Act. When first enacted in 1965, the OAA set out a series of objectives aimed at improving the lives of older Americans in such areas as income, health, housing, employment, community services, and gerontological research and education. Since its inception, the gradual evolution of the programs and services authorized by the OAA has been remarkable. (Although progress has been made, it has not been without some growing pains.)

As originally conceived, the congressional intent underlying the OAA was to establish a coordinated and comprehensive system of services at the community level. Such a system, it was asserted, would provide opportunities for and assistance to vulnerable older persons who, despite advancements in income security and health programs, still needed social services support. Additionally, the structures would provide the supports necessary to promote independent living and reduce the risk of costly institutionalization.

To that end the OAA has been successful. The needs of older persons have been identified and the means for meeting those needs have evolved. There is a now an "aging network" of 57 State units on aging, about 670 area agencies on aging, and more than 25,000 local supportive and nutrition service providers. Additionally, the OAA has been the vehicle for the education and training of thousands in the field of aging.

Despite the increase in appropriations for existing programs in 1991, the programs operated under the Older Americans Act continue to be over-extended and under-funded. Area agencies on aging out of necessity must raise funds from many other sources to support the programs.

Targeting available resources to specific categories of older person—those most in need—is a natural consequence of limited funding. It is also inevitable that those who are most pressed for funding resources on the State and local levels will continue to advocate cost-sharing. However, even if cost-sharing is implemented, it is unlikely to generate sufficient funds to finance services necessary to successfully address the many unmet needs of numerous older Americans.

Although the OAA prohibits the direct provision of services by an area agency on aging, a waiver may be obtained where the State unit on aging determines either that there is no other agency or organization in the area to provide the services or that the area agency on aging can provide the service more economically. Emphasis on the development of long-term care strategies and increasing responsibilities for case management and preadmission assessment have propelled State and area agencies into new areas. It is likely that this trend will continue in the future. This trend may raise difficult issues, such as potential conflicts of interest, that must be resolved in the years to come.

Without question, future demographic changes will place increasing burdens on the programs provided by the OAA. The challenges for State and and area agencies on aging will be not only to maintain necessary services, but also to assure the quality and accessibility of these services. As the past has shown, with continued broad support from the Congress, the OAA can be expected to adapt to and be strengthened from new challenges.

In 1991, advocates and Members of Congress will focus on the reauthorization of the OAA. The controversial issues are not unfamiliar. The primary focus will be on cost-sharing, targeting, and public-private partnerships.

Chapter 14

SOCIAL, COMMUNITY, AND LEGAL SERVICES

OVERVIEW

Social service programs funded by the Federal Government support a broad range of services to older Americans. These programs provide funds to operate a variety of community and social services including home health, programs, legal services, education, transportation, and volunteer opportunities for older Americans.

During the Reagan administration, two basic themes emerged with respect to the delivery of social services for the elderly. First, the administration sought to give States greater discretion in the administration of social services as part of its "New Federalism" initiatives. Second, the shift toward block grant funding was accompanied by a general trend toward fiscal restraint and retrenchment of the Federal role in human services. As a result, the competition for scarce resources accelerated between the elderly and other needy groups.

In addition to cuts accompanying the block grants, the Reagan administration proposed to reduce spending for education, transportation, and legal services. These administrative efforts affected service delivery in varying degrees, with the most significant cuts coming in legal services, which the administration sought to eliminate entirely. Older American volunteer programs, by contrast, had enjoyed strong support from the administration.

For the most part, Congress resisted the administration's efforts to reduce funding for social, community, and legal services. Following cuts sustained in the fiscal year 1981 budget, Congress increased spending for the Social Services Block Grant (SSBG), Community Services Block Grant (CSBG), and legal services. In fiscal year 1985, Congress significantly increased authorized spending levels for adult education and other education programs benefiting the elderly. The focus on Federal spending, however, was clearly framed by the widespread concern over budget deficits.

At the beginning of 1989, advocates of human service programs were hopeful that the combination of a Democratic majority in the Senate and President Bush's call for a "kinder, gentler nation" would result in greater Federal resources being devoted toward social service programs. Although the political climate with respect to human services continued to be more favorable in 1990, there were few tangible results. Most programs were funded at levels comparable to previous years, and no major new initiatives were enacted.

A. BLOCK GRANTS

1. Background

(A) SOCIAL SERVICES BLOCK GRANT

Social services programs are designed to protect individuals from abuse and neglect, to help them become self-sufficient, and to reduce the need for institutional care. Social services for welfare recipients were not included in the original Social Security Act, although it was later argued that cash benefits alone would not meet all the needs of the poor. Instead, services were provided and funded largely by State and local governments and private charitable agencies. The Federal Government began funding such programs under the Social Security Act in 1956 when Congress authorized a dollar-for-dollar match of State social services funding; however, this matching rate was not sufficient incentive for many States, and few chose to participate. Between 1962 and 1972, the Federal matching amount was increased and several program changes were made to encourage increased State spending. By 1972, a limit was placed on Federal social services spending because of rapidly rising costs. In 1975, a new Title XX was added to the Social Security Act which consolidated various Federal social services programs and effectively centralized Federal administration.

Title XX provided 75 percent Federal financing for most social services, except family planning which was 90 percent federally funded. The law required that at least half of each State's Federal allotment be used for services to recipients to Aid to Families with Dependent Children (AFDC), Supplemental Security Income (SSI), or Medicaid. The remaining funds could be used to provide services to anyone whose income did not exceed 115 percent of the State's median income. Fees were mandatory for individuals with incomes between 80 percent and 115 percent of the State median income. All services provided by a State had to be tied to at least one of five legislative goals that related to self-sufficiency and self-support. At least one service for each of the five goals had to be provided. Further, Title XX required States to offer at least three services for aged, blind, or disabled people receiving SSI payments.

In 1981, Congress created the SSBG as part of the Omnibus Budget Reconciliation Act. By eliminating most of the restrictions in Title XX, Congress granted the Reagan administration added flexibility to transfer maximum decisionmaking authority to the States and reduce domestic Federal spending. Under the block grant program, States no longer are required to provide a minimum level of services to AFDC, SSI, or Medicaid recipients, nor are Federal income eligibility limits imposed. Non-Federal matching requirements were eliminated and Federal standards for services, particularly for child day care, also were dropped. The block grant allows States to design their own mix of services and to establish their own eligibility requirements.

Block grant funds are used for such diverse activities as child day care, home-based services for the elderly, protective and emergency services for children and adults, family planning, transportation, staff training, and program planning.

(B) COMMUNITY SERVICES BLOCK GRANT

The CSBG is the current version of the Community Action Program (CAP), which was the centerpiece of the war on poverty of the 1960's. This program originally was administered by the Office of Economic Opportunity within the Executive Office of the President. In 1975, the Office of Economic Opportunity was renamed the Community Services Administration (CSA) and reestablished as an independent agency of the executive branch.

As the cornerstone of the agency's antipoverty activities, the Community Action Program gave seed grants to local, private nonprofit or public organizations designated as the official antipoverty agency for a community. These community action agencies were directed to provide services and activities "having a measurable and potentially major" impact on the causes of poverty. During the agency's 17-year history, numerous antipoverty programs were initiated and spun off to other Federal agencies, including Head Start, legal services, low-income energy assistance and weatherization. Although the agency's budget peaked in fiscal years 1969 and 1970 with an annual funding of $1.9 billion, the funding then steadily declined until fiscal years 1981, when appropriations were $526.4 million.

Under a mandate to assure greater self-sufficiency for the elderly poor, the CSA was instrumental in developing programs that assured access for older persons to existing health, welfare, employment, housing, legal, consumer, education, and other services. Programs designed to meet the needs of the elderly poor in local communities were carried out through a well-defined advocacy strategy which attempted to better integrate services at both the State level and the point of delivery.

In 1981, the Reagan administration proposed elimination of the CSA and the consolidation of its activities with 11 other social services programs into a Social Services Block Grant as part of an overall effort to eliminate categorical programs and reduce Federal overhead. The administration proposed to fund this new block grant in fiscal year 1982 at about 75 percent of the 12 programs' combined spending levels in fiscal year 1981. Although the General Accounting Office and a congressional oversight committee had criticized the agency as being inefficient and poorly administered, many in Congress opposed the complete dismantling of this antipoverty program. Consequently, the Congress in the Omnibus Reconciliation Act of 1981 (P.L. 97-35) abolished the CSA as a separate agency, but replaced it with the CSBG to be administered by the newly created Office of Community Services under the Department of Health and Human Services.

The CSBG Act requires States to submit an application to the Department of Health and Human Services, promising the State's compliance with certain requirements, and a plan showing how this promise will be carried out. States must guarantee that legislatures will hold hearings each year on the use of funds. States also must agree to use block grants to promote self-sufficiency for low-income persons, to provide emergency food and nutrition services, to coordinate public and private social services programs, and to encourage the use of private-sector entities in antipoverty activities. However, neither the plan nor the State application is subject to the approval of the Secretary. States may transfer up to 5 percent of their block grant allotment for use in other programs, such as the Older Americans Act, Head Start, and low-income energy assistance. No more than 5 percent of the funds may be used for administration.

Funding for the new block grant in fiscal year 1982 amounted to a 30-percent reduction from the CSA's fiscal year 1981 appropriation. The CSBG received $348 million in fiscal year 1982, plus an additional $18 million for activities related to the phaseout of the CSA.

Since States had not played a major role in antipoverty activities when the CSA existed, the Reconciliation Act of 1981 offered States the option of not administering the new CSBG during fiscal year 1982. Instead, the Department of Health and Human Services would continue to fund existing grant recipients until the States were ready to take over the program. States which opted not to administer the block grant in 1982 were required to use at least 90 percent of their allotment to fund existing community action agencies and other prior grant recipients. In the act, this 90 percent pass-through requirement applied only during fiscal year 1982. However, in appropriations legislation for fiscal years 1983 and 1984, Congress extended the grandfather provision to ensure program continuity and viability. The extension was viewed widely as an acknowledgment of the political stakes inherent to community action agencies and the programs they administer.

In 1984, Congress made the 90 percent pass-through requirement permanent and applicable to all States under Public Law 98–558. Currently, over 1,145 eligible service providers receive funds under the 90 percent pass-through. Three-fourths of these entities are community action agencies, the remainder includes limited purpose agencies, migrant or seasonal farmworker organizations, local governments or councils of government, and Indian tribes or councils.

In 1989, the National Association for State Community Services Programs released a 50-State survey of programs funded by CSBG. Among the principal findings were: (1) 92 percent of CSBG funds are received by local agencies eligible for the congressionally mandated pass-through; (2) 73 percent of such eligible agencies are community action agencies established under the original CAP; (3) 76 percent of the funds received by CSBG-funded agencies come from Federal programs; (4) 6 percent of funds received by CSBG-funded agencies come from State government sources; and (5) CSBG moneys constitute only 8 percent of the total funds received by CSBG-funded agencies.

Agencies from 31 States reported detailed information about their uses of CSBG funds. Those agencies used CSBG moneys in the following manner: emergency services (20 percent), nutrition programs (14 percent), employment programs (13 percent), education initiatives (8 percent), neighborhood and economic development (8 percent), income management programs (8 percent), and housing initiatives (6 percent).

2. ISSUES

(A) NEED FOR COMMUNITY SERVICES BLOCK GRANTS

After 2 years of existence, the administration proposed to terminate the CSBG entirely for fiscal year 1984, and to direct States to use other sources of funding for anti-poverty programs, particularly SSBG dollars. In justifying this phaseout and suggesting funding through the SSBG, the administration maintained that States would gain greater flexibility because the SSBG suggested fewer restrictions. According to the administration, States then would be able to develop the mix of services and activities that were most appropriate to the unique social and economic needs of their residents.

However, a General Accounting Office (GAO) report refutes this claim.

In May 1986, GAO issued a report on the operation of Community Action Agencies (CAA's) funded by the CSBG. Specifically, the GAO addressed the Reagan administration's position that:

(1) The type of programs operated under CSBG duplicated social service programs under the SSBG,

(2) CAA's can find other Federal and State funds to cover administrative activities, and

(3) Funding under CSBG is not essential to the continued operation of CAA's.

The report found that, in general, CSBG-funded services often were short-term and did not duplicate those provided under SSBG. Primarily, CSBG funds are used to provide services that fulfill unmet local needs and to complement those services provided by other agencies. Unmet local needs cited by GAO include temporary housing, transportation, and services for the elderly. CSBG-funded agencies provided such complementary programs as the training of day care personnel for SSBG-funded day care programs and temporary shelter for clients awaiting more permanent housing financed by other sources. The most predominant CSBG-funded services found by GAO were information, outreach, and referral, as well as emergency and nutritional services.

GAO also found that CSBG funds often are used for administration of other social service programs, which may have limitations on the use of their own funds for administrative expenses. Consequently, CAAs are not in a position to find other Federal and State funds to cover administrative costs. According to GAO, the Federal Government in 1984 provided 89 percent of the total funs received by CAAs in 32 States. The remaining 11 percent of the 1984 budgets of reporting CAAs were provided by CSBG funds. Several other Federal programs, including Head Start, the Community Development Block Grant, and Low-Income Home Energy Assistance, provide substantial CAA funding.

The GAO report also did not support the administration's claims that CSBG funding is nonessential to continued program operation. State and local governments are under such fiscal duress that they may not be able to replace lost CSBG funds.

The administration continued to attempt termination of the CSBG in fiscal years 1985–87, requesting funding only to cover administrative expenses of closing down the program. For fiscal years 1988 and 1989, the administration requested $310 million and $282 million respectively for a 4-year phase-out of the CSBG program. Congress, however, has resisted the administration's proposals and continues to support funding for the operation of the CSBG program.

(B) ELDERLY SHARE OF SERVICES

The role that the Social Services Block Grant plays in providing services to the elderly had been a major concern to policymakers. Supporters of the SSBG concept have noted that social services can be delivered more efficiently and effectively due to administrative savings and the simplification of Federal requirements. Critics, on the other hand, have opposed the block grant approach because of the broad discretion allowed to States and the loosening of Federal restrictions and targeting provisions that assure a certain level of services for groups such as the elderly. In addition, critics have noted that any future reductions in SSBG funding could trigger uncertainty and increased competition between the elderly and other needy groups for scarce social service resources.

Under Title XX, the extent of program participation on the part of the elderly was difficult to determine because programs were not age specific. States had a great deal of flexibility in reporting under the program, and, as a result, it was hard to identify the number of elderly persons served, as well as the type of services they received. The elimination of many of the reporting requirements under SSBG has made efforts to track services to the elderly even more difficult. States are required to file yearly pre-expenditure reports, but these do not adhere to a standardized format and are of limited value in determining the impact of program and funding changes on specific populations.

In 1989, the American Association of Retired Persons conducted a survey of States to determine the amount of SSBG funds being used for services to the elderly. The survey showed that 47 States use some portion of their SSBG funds to provide services to older persons. The percentage of Federal funds used for seniors ranged from 0 to 90 percent in 39 States that were able to provide age-specific estimates. Most States indicated that they have held service levels relatively constant by a variety of devices, including appropriating their own funds, cutting staff, transferring programs to other funding sources, requiring local matching funds, or reducing the frequency of services to an individual. The most frequently provided services were home-based, adult protective, and case management/access. Other uses include family assistance, transportation, nutrition/meals, socialization and disabled services. All but 3 of the 47 States responding to the survey reported that services for older people have suffered from the absence of increases in Federal SSBG funding. As a result, States have raised the eligibility criteria so that they provide fewer and less comprehensive services to fewer people, and except with respect to protective services, they serve only the very low-income elderly. In addition, some States reported that shrinking funds make it necessary to consider the costs of services more than the quality of services.

It seems clear that while funding for the SSBG has remained relatively constant, there is a strong potential for fierce competition among competing recipient groups. Increasing social service needs along with declining support dollars portends a trend of continuing political struggle between the interests of elderly indigent and those of indigent mothers and children. In the coming years, a fiscal squeeze in social service programs could have massive political reverberations for Congress, the administration, and State governments as policymakers contend with issues of access and equity in the allocation of scarce resources.

The proportion of CSBG funds that support services for the elderly and the extent to which these services have fluctuated as a result of the block grant also remains unclear. When the CSBG was implemented, many of the requirements for data collection previously mandated and maintained under the Community Services Administration were eliminated. States were given broad flexibility in deciding the type of information they would collect under the grant. As a result of the minimal reporting requirements under the CSBG, there is very little information available at the Federal level regarding State use of CSBG funds.

A 1989 study by Economic Opportunity Research Institute and the National Association for State Community Services Program (NASCSP), on State use of fiscal year 1987 CSBG funds provides some interesting clues. Although the survey was voluntary, all jurisdictions eligible for CSBG allotments answered all or part of the survey. Thus, NASCSP received data on CSBG expenditures broken down by program category and number of persons served which provides an indication of the impact of CSBG services on the elderly. For example, data from 31 States show expenditures for employment services, which includes job training and referral services for the elderly, accounted for 13 percent of total CSBG expenditures in those States and served over 1 million persons. Housing programs, in fiscal year 1987, including home ownership counseling, shelters for the homeless, and construction of low-cost housing, also served over 1 million persons, many of whom are elderly. A catchall linkage program category supports a variety of services reaching older persons, including transportation services, medical and dental care, senior center programs, legal services, homemaker and chore services, and information and referrals. Emergency services such as donations of clothing, food, and shelter, low-income energy assistance programs and weatherization are provided to the needy elderly through CSBG funds. Unfortunately, data related to the age, sex, race, and income levels of program participants were not reported in the survey. Until such data are available, a definitive picture of the role CSBG programs play in assisting the needy elderly is unclear.

3. Congressional Response

(A) SOCIAL SERVICES BLOCK GRANT APPROPRIATIONS

The 1981 Budget Reconciliation Act fixed authorization levels 20 percent below those in fiscal year 1981, with slight increases for inflation. Authorization levels were set at $2.4 billion in fiscal year 1982, $2.45 billion in fiscal year 1983, $2.5 billion in fiscal year

1984, $2.6 billion in fiscal year 1985, and $2.7 billion in fiscal year 1986 and beyond. The program is permanently authorized. States are entitled to receive a share of the total according to their population size.

For fiscal year 1986, President Reagan requested that the full entitlement level of $2.7 billion be appropriated for the SSBG, and Congress appropriated that amount. However, under the Gramm-Rudman-Hollings deficit reduction procedures, $116 million was lost through automatic sequestration. Although the Supreme Court invalidated the process, Congress upheld the budget cuts in March 1986 with Public Law 99-366.

The President again requested $2.7 billion for the SSBG for fiscal years 1987-89, the full amount authorized by law. Congress incorporated the $2.7 billion into a governmentwide continuing appropriations resolution for fiscal year 1987 (P.L. 99-591) and authorized a one-time $50 million increase for fiscal year 1988 for a total of $2.75 billion (P.L. 100-202). However, this additional $50 million was not appropriated and $2.7 billion was provided for the SSBG in fiscal year 1988. Congress appropriated the full authorized amount of $2.7 billion again for fiscal year 1989 (P.L. 100-436). Effective in fiscal year 1990, Congress increased the authorization level for the SSBG to $2.8 billion (P.L. 101-239). This full amount was appropriated for both fiscal year 1990 and fiscal year 1991 (P.L. 101-166 and P.L. 101-517).

(B) COMMUNITY SERVICES BLOCK GRANT REAUTHORIZATION AND APPROPRIATIONS

As established in the 1981 Omnibus Budget Reconciliation Act, the Community Services Block Grant (CSBG) was scheduled to expire at the end of fiscal year 1986. The Human Services Reauthorization Act of 1986 (P.L. 99-425) extended the CSBG Act through fiscal year 1990 and Public Law 101-501 subsequently extended the act through fiscal year 1994 at the following funding levels: $451.5 million in fiscal year 1991, $460 million in fiscal year 1992, $480 million in fiscal year 1993, and $500 million in fiscal year 1994. Of the total appropriated each year, the Secretary of the Department of Health and Human Services is authorized to reserve up to 9 percent for discretionary use. The remaining funds are allotted to States in the same proportion as the amounts that the States received in fiscal 1981 from CSA. Ninety percent of the State allotments must be used to fund eligible service providers.

The act also authorizes the following amounts for the Community Food and Nutrition Program: $10 million in fiscal year 1991, $15 million in fiscal year 1992, $20 million in fiscal year 1993, and $25 million in fiscal year 1994. In addition, the following amounts are authorized for demonstrations of innovative antipoverty approaches: $10 million in fiscal year 1991, and such sums as necessary for fiscal years 1992, 1993, and 1994. The Stewart McKinney Homeless Assistance Act authorized appropriations for grants to States for services to the homeless.

The Reagan administration submitted similar budget requests for the CSBG for several years. It hoped to close down the CSBG during each of the fiscal years 1984 through 1987. For example, only $3.6 million was requested for fiscal year 1987 to cover Federal administrative expenses related to the phasing out of the program. However, Congress continually rejected these proposals and appropriated funds for CSBG throughout the Reagan years.

In an apparent change of strategy, the Bush administration requested $310 million for the CSBG program for fiscal year 1988 and $282 million for fiscal year 1989 to begin a 4-year phaseout of the CSBG program. No appropriations were requested by the administration for the Community Food and Nutrition Program for fiscal year 1989. In addition, the administration made no request for extension of the authorization of homeless services.

For fiscal year 1990, Congress appropriated $397 million for CSBG, including $21.9 million for homeless services, $3.5 million for community partnerships, and $2.4 million for nutrition services. For fiscal year 1991, Congress appropriated a total of $428 million for CSBG and related activities, including $33 million for homeless services, $4 million for demonstration community partnerships, and $2.4 million for nutrition services.

B. EDUCATION

1. BACKGROUND

State and local governments have long had primary responsibility for the development, implementation, and administration of primary, secondary, and higher education, as well as continuing education programs that benefit students of all ages. The role of the Federal Government in education has been to ensure equal opportunity, to enhance the quality, and to address national priorities in training.

Federal and State interest in developing educational opportunities for older persons grew out of a paper prepared for the 1971 White House Conference on Aging which cited a list of educational needs for older persons. These range from the need to acquire the basic skills necessary to function in society, to the need to engage in activities throughout one's life which are enjoyable and meaningful and which benefit other people. The 1981 White House Conference on Aging report, entitled "Implications for Educational Systems," noted that as our society ages at an accelerated rate, it must assess and redefine the teaching and learning roles of older persons and assure a match between the needs of older adults and the training of those who serve them.

While many strong arguments exist for the importance of formal and informal educational opportunities for older persons, it has traditionally been a low priority in education policymaking. Public and private resources for the support of education have been directed primarily at the establishment and maintenance of programs for children and college age students. This is due largely to the perception that education is a foundation constructed in the early stages of human development.

While formal education is viewed as a finite activity extending only through early adulthood, learning continues throughout one's life in experiences with work, family, and friends. Thus, it is a relatively new notion that the elderly have a need for learning beyond the informal environment. This need for structured learning may appeal to "returning students" who have not completed their formal education, older workers who require retraining to rapid technological change, or retirees who desire to expand their knowledge and personal development. A growing awareness of the importance of education to the elderly has resulted in some reordering of priorities and resource allocation away from the basic education/literacy and training programs established for older adults in the early 1960's. While Federal programs generally have lagged, private and public-based education programs have emerged that are designed to better meet the growing educational needs of older persons.

2. ISSUES

(A) ADULT LITERACY

Conventional literacy means the ability to read and write. The Census Bureau estimated that the Nation's conventional illiteracy rate was 0.5 percent in 1980, which would place the estimated number at over 1 million. However, literacy means more than the ability to read and write. The term "functional illiteracy" began to be used during the 1940's and 1950's to describe persons who were incapable of understanding written instructions necessary to accomplish specific tasks or functions.

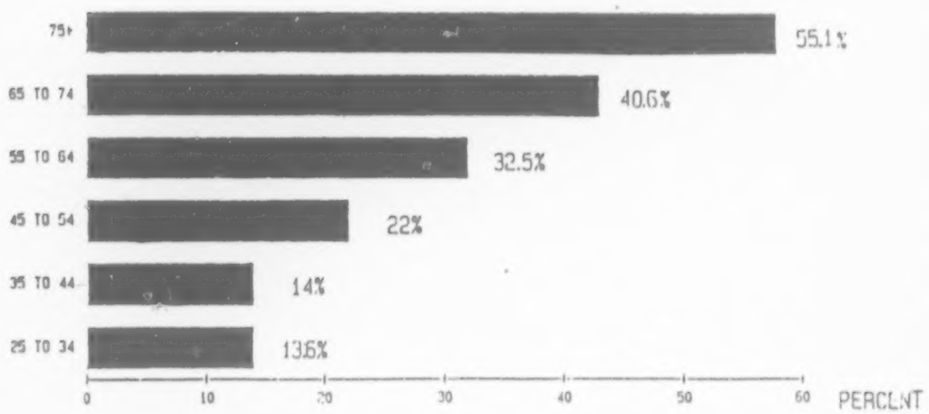
Definitions of functional literacy depend on the specific tasks, skills, or objectives at hand. As various experts have defined clusters of needed skills, definitions of functional literacy have proliferated. These definitions have become more complex as technology and information has increased. Despite a consensus that some definition of functional illiteracy must replace the conventional definition, no agreement has been reached. Without a standard definition and widely accepted measure of illiteracy, it is difficult to determine the extent of illiteracy in the country and whether it is increasing or decreasing.

The results of some studies, however, have revealed cause for concern. In a 1986 study of illiteracy by the National Advisory Council on Adult Education, an estimated 40 percent of armed services enlistees were found to read below the 9th grade level. An estimated two-thirds of the Nation's colleges find it necessary to provide remedial reading and writing courses. When the inherent problems associated with illiteracy are considered—unemployment, crime, homelessness, alcohol, and drug abuse—the social consequences of widespread illiteracy in this country are disturbing.

Of all adults, the group 60 years of age and older has the highest percentage of people who are functionally illiterate. However, results of one study showed that 35 percent of adults 60 to 65 years of age lack the skills and knowledge necessary to cope successfully in today's society. According to 1982 census data, nearly one-third of all illiterate adults are age 60 and over. These figures reflect the direct correlation between educational attainment and literacy. As would be expected, there is a heavy concentration of older persons among the group of adults 16 years of age and over with less than a high school education.

CHART 1

PERCENT OF AGE GROUPS WITH LESS THAN 12 YEARS OF EDUCATION: 1907



Source: U.S. Bureau of Census, Current Population Survey,
March, 1988

Data from the Office of Vocational and Adult Education within the Department of Education (ED), shows that in 1986 of the total eligible adult population receiving Adult Basic Education services (ABE)—basic literacy and English as a second langauge instruction, 7.4 percent or 217,488 were in the 60-plus age group, as compared to 185,000 the previous year, an 11.8-percent increase. On the State levels, the percentages of older adult participation in literacy instruction varied from less than 1 percent to 20 percent. The reasons for participation in literacy programs most often cited by this group were a desire (1) to read to their grandchildren, (2) to read the Bible, (3) to read medicine lables, (4) to accomplish a lifetime goal of earning a General Education Development (GED) certificate, (5) to learn more about money and banking, and (6) to learn more about available community resources.

(B) PARTICIPATION IN ADULT EDUCATION

The Department of Education is authorized under the Adult Education Act (AEA) to provide funds for educational programs and support services benefiting all segments of the eligible adult population. The purpose of the act is to (a) establish adult education programs to help persons 16 years and older to acquire basic literacy skills necessary to function in society, (b) enable adults to complete a secondary school education, and (c) make available to adults the means to secure training and education that will enable them to become more employable, productive, and responsible citizens. Funds provided for adult education are distributed by a formula to States based on the number of adults in a State without high school diplomas who currently are not enrolled in school. The AEA served approximately 4 million participants in 1991.

In 1977, a major change began in adult education. Enrollment of persons aged 16 to 44 decreased while the enrollment of persons 45 to 65 increased. A 1984 survey conducted by the National Center for Education Statistics revealed that 866,000 persons age 65 and older, or 3.3 percent of all older Americans, participated in educational activities. Although the majority of adult education participants are under 35, this marked the highest number and percentage of older people involved in adult education ever recorded by the National Center for Education Statistics. However, this represents an increase of only 0.2 percent from a similar 1981 study.

With less than 4 percent of the elderly population enrolled in an educational institution or program today, older Americans continue to be underrepresented in education programs in relation to the percentage of the total U.S. adult population they comprise. This is due partly to the fact that while the elderly certainly have the ability to learn, the desire to learn is a function of educational experience. A 1984 Department of Education report supports the correlation between years of schooling completed and participation in adult education.

The existence of special classes and programs geared to older adults within structured adult education programs is still relatively rare except in community senior centers. Most of the classes focus on self-enrichment and life-coping skills and gradually are shifting to educational programs on self-sufficiency. Few programs currently exist to meet the growing demand to acquire the skills needed for volunteer or paid work later in life. As the median years of schooling for older adults increases, and older persons look to continued employment as a source of economic security, adult education programs may need to shift emphasis from personal interest courses to courses on job-training skills.

Although States use various methods for reaching the eligible aging population, reports indicate that there are problems in carrying out this effort. The major problems most often mentioned by States are transportation and recruitment. Reaching older persons, especially in rural areas, is complicated because of distance, low population density, and lack of public transportation.

3. FEDERAL AND PRIVATE RESPONSE

(A) PROGRAMS

(1) Literacy

(a) Public efforts

The first significant Federal adult literacy programs began in the military services. Programs for civilians started with the Manpower Development and Training Act of 1964, providing job training for the unemployed. Many participants were found to be functionally illiterate and the program was amended to provide basic educational skills. The Economic Opportunity Act of 1964 provided the first State grants for persons needing basic literacy skills. The Adult Education Act was enacted as part of the Elementary and Secondary Education Amendments of 1966 (P.L. 89-750). The act has been amended several times since 1966, but the basic purpose and structure has remained the same.

During its first term, the Reagan administration requested a one-third reduction of Federal funds for the Adult Education Act, with the ultimate intent of turning over such programs to the States under the "Federalism Initiative." In response to the President's Commission on Excellence in Education report, the Reagan administration made the elimination of illiteracy a major focus. The Adult Literacy Initiative was launched in the Department of Education on September 7, 1983. It is not a legislatively mandated program, but is based on various discretionary authorities available to the Secretary of Education. The thrust of the initiative is to increase public awareness of the problem, recruit volunteer tutors, and encourage private sector involvement.

The program's current accomplishments include:

(1) Cooperating with the Coalition for Literacy and the Advertising Council in sponsoring a National Awareness Campaign on adult literacy, including a toll-free "Literacy Hotline",

(2) Redirecting part of the College Work-Study Programs to employ students in literacy programs,

(3) Encouraging student and adult volunteers as literacy tutors,

(4) Working with the Federal Employee Literacy Training program, whereby all Federal agencies are encouraging employees to volunteer as literacy tutors,

(5) Sponsoring national meetings and conferences, and

(6) Developing private/public sector partnerships, including support for the Business Council for Effective Literacy.

The Department of Education's Office of Educational Research and Improvement sponsored the National Adult Literacy Project, which issued research reports in 1985 on a number of topics, including history and description of adult basic education programs, literacy and employment, an agenda for literacy research and development, support systems for adult education, literacy, and television, alternative strategies for adult education participation, and a guidebook on effective literacy projects.

Much of the public effort by States and localities to address literacy problems is organized under the AEA program, which is federally funded and State administered. Section 353 of the Adult Education Act requires States to set aside 10 percent of their Federal funds for special experimental demonstration and teacher training projects. The section calls for coordinated approaches to the delivery of adult basic education services to promote effective programs and to develop innovative methods. Some of the States developed projects targeted to improve literacy services to the older population. For example, Louisiana developed a set of basic skills curricula for adults reading at the 0-4 grade levels and West Virginia used cable television to reach the disadvantaged who live in rural areas, are institutionalized, homebound, or isolated.

(b) Private efforts

Literacy programs are operated by a multitude of private groups including churches, businesses, labor unions, civic and ethnic groups, community and neighborhood associations, museums and galleries, and PTA groups. Two national groups provide voluntary tutors and instructional materials for private literacy programs, the Laubach Literacy Action (50,000 tutors) and Literacy Volunteers of America (30,000 tutors). At the instigation of the American Library Association, a group of 11 national organizations, including Laubach and Literacy Volunteers, created the Coalition for Literacy to deliver information and services at the national and local levels. The Coalition and the Advertising Council began a 3-year advertising project in December 1984, the National Literacy Awareness Campaign, to increase public awareness and recruit literacy volunteers.

The Business Council for Effective Literacy is a foundation established in 1984 to foster "corporate awareness of adult functional illiteracy and to increase business involvement in the literacy field." The Council's quarterly newsletters contain descriptions of many current public and private literacy efforts.

(2) Higher Education

Older persons bring insight, interest, and commitment to learning that can generate similar enthusiasm from younger classmates, and can add to the personal satisfaction of learning. A logical extension of the success of intergenerational school programs is the intergenerational classroom at the college level. A recent study found that younger students studying together with persons their parents' and grandparents' age broadened their attitude toward older persons beyond rigid stereotypes and enabled them to identify their older classmates as their peers. This finding rebukes the myth that older students somehow take away learning opportunities from younger students, and indicates a growing need to think of older adults as a vital part of the college classroom.

Some colleges have designed continuing education programs to provide the flexibility and support older students often need when reentering college ~~after~~ several years. Approximately 93 colleges and universities participate in the College Centers for Older Learners (COOL) program. The two most common variations of this program are either those curricula that are planned and implemented exclusively by older persons, or those that are designed and managed by the institution with involvement of older students in the program planning.

Other colleges recognize experience as credit hours. At American University in Washington, DC, for example, the Assessment of Prior Experiential Learning (APEL) program allows older students to translate their years of work or life experience into as many as 30 credits toward a bachelor's degree.

For those older students who cannot afford the cost of a private college, some States are beginning to reduce the cost of higher education for adults age 60 and over. Although policies differ from State to State, most offer full tuition waiver and allow participants to take regular courses for credit in State-supported institutions. The Older Americans Act (OAA) Amendments of 1987 (P.L. 100–175) included a provision which requires area agencies on aging to conduct a survey on the availability of tuition-free post-secondary education in their area, supplement the data where necessary, and disseminate this information through senior centers, congregate nutrition sites, and other appropriate locations. It is anticipated that access to such information will increase the enrollment of older persons in higher education programs.

(3) Elderhostel

Elderhostel was inspired by the youth hostels and folk schools of Europe, and is based on the belief that retirement and later life represents an opportunity to enjoy new experiences. Elderhostels are short-term residential, campus-based educational programs provided to older persons at modest cost. Courses offered are in the liberal arts and sciences and presuppose no particular level of formal education on the part of the student. Most Elderhostel programs deliberately avoid an age-specific focus.

Since the inception of Elderhostel in New Hampshire in 1975, enrollment of older adults in such programs has dramatically increased. In 1988, more than 900 private and public colleges and educational institutions in 50 States and Canada served 163,000 summer and academic year hostelers. In addition, hostelers participated in programs in 40 other countries including Scandinavia, France, Germany, the Netherlands, Italy, Great Britain, Israel, and

Australia. Even with the burgeoning numbers of participants, however, Elderhostel remains essentially an educational opportunity reserved for mobile older adults with a relatively high education attainment level.

(4) Intergenerational Programs

Intergenerational programs in schools were introduced in the early 1970's in an effort to counter the trend toward an increasingly agesegregated society in which few opportunities exist for meaningful contact between older adults and youth. Initially, programs were designed and implemented with an emphasis toward providing the support, teaching, and caring that would enhance the learning and development of schoolchildren. Eventually, intergenerational school programs emerged as a viable means of enriching the lives of older persons as well. There are now more than 100 intergenerational school programs nationwide. More than 250,000 volunteers participate in grades kindergarten through 12.

Intergenerational school programs range from informal and haphazard to large, centrally organized projects spanning several school districts. One example of a successful intergenerational program is the Teaching Learning Community, established by an elementary art teacher in 1971 in Ann Arbor, MI. Teaching Learning Community links older persons with a small group of student-apprentices. They work together on joint activities on a regular, weekly basis. The focus is to teach the student a new skill and create a product, while communicating with and developing respect for others. The program has spread to many States, including Florida, Pennsylvania, Idaho, Texas, and New York.

Whatever the size or scope, intergenerational school programs contribute immeasurably toward improving older persons' self-esteem and life satisfaction. School volunteering provides an opportunity for older persons to develop meaningful relationships with children and to better cope with their own personal traumas, such as the death of a spouse or friend. These programs also allow schoolchildren to develop a more positive view of the elderly while benefiting from the social and academic experience of their older tutors.

The Federal role in promoting intergenerational school programs has expanded recently through a joint initiative sponsored by the Administration on Aging and the Administration for Children, Youth, and Families in the Department of Health and Human Services. This Federal effort consists of four major components:

(1) Establishing an information bank of intergenerational programs across the country,

(2) Disseminating this information to organizations interested in establishing such programs,

(3) Working with professional organizations to stimulate interest, and

(4) Funding intergenerational demonstration projects. For example, the Administration on Aging, working cooperatively with 12 foundations, has funded 9 intergenerational projects throughout the country. These projects include intergenerational child care programs, a telephone help line operated by

frail elderly for latch-key children; senior homesharing; and a senior mentor program.

The Older Americans Act Amendments of 1987 included a provision that allows the Commissioner on Aging to award demonstration grants to provide expanded, innovative volunteer opportunities to older persons and to fulfill unmet community needs. These projects may include intergenerational services by older persons to meet the needs of children in day care and school settings. For fiscal year 1990, the Administration on Aging funded a number of grants for model intergenerational programs. In addition, Head Start funded a number of projects involved in intergenerational volunteer projects, which are to be jointly funded by AoA and Head Start in fiscal year 1991.

In the spring of 1989, the Special Committee on Aging conducted a field hearing, chaired by Senator Bob Graham, in Boca Raton, FL, which further highlighted the success of intergenerational educational partnerships.

(B) LEGISLATION

In 1990, Congress enacted no major measures related to the Adult Education Act and other literacy/education programs. However, several pieces of legislation passed in 1988 which remain of interest to those following adult literacy and education issues. These include:

(1) The Hawkins-Stafford Elementary and Secondary School Improvement Amendments of 1988 became Public Law 100-297 on April 28, 1988. This legislation amends and extends the AEA through fiscal year 1993 and strengthens AEA provisions for programs serving educationally disadvantaged adults. Two new AEA programs were authorized: workplace literacy partnership grants and English literacy grants. Demonstration grants for literacy partnerships provide adult literacy and training skills to improve the productivity of the work force. Partnerships consist of (a) business, industry, labor organizations, or private industry councils, and (b) State or local educational agencies, institutions of higher education, or schools. Demonstration grants for English literacy assist programs for adults with limited English proficiency. The amendments also authorized an "Even Start" program for adult literacy for parents and their children.

Further, the amendments required the Secretary of Education to establish an information clearinghouse on literacy curricula, define the basic skills needed for literacy, and estimate the number of illiterate adults in the country. In addition, the Secretaries of the Departments of Education, Labor, and Health and Human Services were required to conduct a joint study of Federal funding sources and services currently available for adult education programs and are to jointly facilitate interagency coordination. The findings of the study are to be submitted to Congress within 1 year.

The Hawkins-Stafford Amendments also extended the Ellender Fellowship program. Ellender grants are made to the Close-up Foundation which provides educational programs on

Federal Government activities and public affairs, usually bringing participants to Washington, DC, for this purpose. A new provision authorized fellowships for older Americans and recent immigrants.

(2) The Stewart B. McKinney Homeless Assistance Act of 1987 (P.L. 100-77) authorized an Adult Education for the Homeless program which provided States with grants to develop and implement a program of literacy training and basic skills remediation. The States, in turn, coordinate these programs with community-based organizations, VISTA recipients, adult basic education program recipients, and nonprofit literacy-action groups. Funds are allocated according to each State's homeless population, with each State receiving at least $75,000.

Section 701 of the McKinney Act also amends the Adult Education Act to include homeless individuals as a category in the research and demonstration program. The Stewart B. McKinney Homeless Assistance Amendments Act of 1988 (P.L. 100-628) reauthorized the two programs for 2 years, through fiscal year 1990.

(3) The Omnibus Trade and Competitiveness Act of 1988 was signed into law on August 23, 1989 (P.L. 100-418). The Trade Act contained several identical or similar provisions, such as the partnership and English literacy grants, as contained within the Hawkins-Stafford Amendments. Among the vocational, postsecondary, and adult education provisions, the act created a Federal Literacy Coordination Office, directed the National Diffusion Network to disseminate literacy skills information, established a technological literacy demonstration program, and amended the Job Training Partnership Act (JPTA) to provide employment and training assistance for dislocated workers, including basic and remedial education, and literacy and English training for non-English-speaking persons.

Although Congress did not authorize new adult education and literacy initiatives in 1990, it did increase fiscal year 1991 appropriations for most of the existing programs. The adult education programs received a combined appropriation of $238.8 million for fiscal year 1991, including $10 million for homeless literacy, $19.3 million for literacy partnerships, and $1 million for English literacy. The AEA grants to States total $201 million for fiscal year 1990, a substantial increase over the fiscal year 1990 level.

The 101st Congress considered several comprehensive proposals to improve the Nation's literacy, including the National Literacy Act of 1990. However, none of this legislation was enacted into law. These proposals would have increased funding or established new programs for adult education, workplace literacy and basic skills, research and development, Federal program coordination, State resources and technical assistance, family literacy programs, library programs, and volunteer and community programs.

On a positive note, Public Law 101-645 was enacted which extends the authorization for the literacy training program for homeless adults through fiscal year 1992. In addition, Public Law 101-610 was enacted, which includes provisions to establish programs for adult volunteers to improve basic skills and reduce illiteracy.

C. ACTION PROGRAMS

1. BACKGROUND

ACTION was established in 1971 through a Presidential reorganization plan that brought together under one independent agency several existing volunteer programs. The programs transferred to ACTION in 1971 include Volunteers in Service to America (VISTA) and the National Student Volunteer Program, both previously administered by the Office of Economic Opportunity, the Foster Grandparent Program (FGP), and the Retired Senior Volunteer Program (RSVP), which had been part of the Administration on Aging.

ACTION was given statutory authority under the Domestic Volunteer Service Act of 1973, which placed all domestic volunteer programs under a single authorizing statute. The act was reauthorized in 1989 through fiscal year 1993.

Today, programs administered by ACTION include the Title I-A VISTA program, the Title I-B student community service programs, the Title I-C special volunteer programs, and the Title II Older American Volunteer Programs (FGP, RSVP, and the Senior Companion Program). ACTION programs are directed toward reducing poverty and poverty-related problems, helping the physically and mentally disabled, and assisting in a variety of other community service activities. ACTION also supports demonstration projects for testing new initiatives in voluntarism, and advocates and promotes voluntarism in the public and private sectors.

(A) OLDER AMERICAN VOLUNTEER PROGRAMS

The Older American Volunteer Programs (OAVP), which includes the RSVP, the FGP, and the Senior Companion Program (SCP), is the largest of the ACTION program components. For fiscal year 1990, OAVP funding constituted 67 percent of total ACTION funding, and continues to support the majority of ACTION's volunteer strength. The various programs provide opportunities for persons 60 years and older to work part time in a variety of community service activities. Grants are awarded to local private nonprofit or public sponsoring agencies that recruit, place, supervise, and support older volunteers.

A significant facet of the OAVP is the extent to which Federal funding is supplemented by State and local governments, as well as private sector resources. According to ACTION estimates, non-Federal funding to support ACTION-sponsored volunteer projects is estimated at more than $60 million annually. In the past few years, State funds to support each of the programs have exceeded the Federal requirements for matching funds. Because these projects continue to generate additional funding at the State and local level and are a cost-effective means of providing community services, they are enormously popular with both Congress and the administration.

(1) Retired Senior Volunteer Program

Retired Senior Volunteer Program (RSVP) was authorized in 1969 under the Older Americans Act. In 1971, the program was transferred from the Administration on aging to ACTION and in 1973 the program was incorporated under Title II of the Domestic Volunteer Service Act. RSVP is designed to provide a variety of volunteer opportunities for persons 60 years and older. In fiscal year 1989, there were 750 projects and 400,000 RSVP volunteers who are estimated to have generated approximately 73 million volunteers hours. This includes volunteers supported by non-Federal funds as well as federally funded volunteers. Volunteers serve in such areas as youth counseling, literacy enhancement, long-term care, refugee assistance, drug abuse prevention, consumer education, crime prevention, and housing rehabilitation. Program sponsors include State and local governments, universities and colleges, community organizations, and senior service groups.

Each project is locally planned, operated, and controlled. Although volunteers do not receive hourly stipends as under the Foster Grandparent and Senior Companion Programs, they receive reimbursement for out-of-pocket expenses incurred as a result of the volunteer activities.

(2) Foster Grandparent Program

The Foster Grandparent Program (FGP) program originated in 1956 as a cooperative effort between the Office of Economic Opportunity and the Administration on Aging. It was authorized under the Older Americans Act in 1969 and 2 years later transferred from the Administration Aging to ACTION. In 1973, the FGP was incoporated under Title II of the Domestic Volunteer Service Act.

The FGP provides part-time volunteer opportunities for low-income persons 60 and older to assist them in providing supportive services to children with physical, mental, emotional, or social disabilities. Foster grandparents are placed with nonprofit sponsoring agencies such as schools, hospitals, day-care centers, and institutions for the mentally or physically handicapped. Volunteers serve 20 hours a week and provide care on a one-to-one basis to three or four children. A foster grandparent may continue to provide services to a mentally retarded person over 21 years of age as long as that person was receiving services under the program prior to becoming age 21.

The FGP was originally intended for low-income volunteers who received an hourly stipend. The Domestic Volunteer Service Act exempts stipends from taxation and from being treated as wages or compensation. Foster grandparent volunteers must have an income below the higher of 125 percent of the Department of Health and Human Services poverty guidelines or 100 percent of those guidelines plus the amount each State supplements the Federal Supplemental Security Income payment. In 1990, this annual income level was $6,280 for an individual in most States, and $8,420 for a two-person family.

In an effort to expand volunteer opportunities to all older Americans, Congress added an amendment to the 1986 Amendments (P.L. 99-551) which permitted non-low-income persons to become foster grandparents. The non-low-income volunteers are reimbursed for out-of-pocket expenses only.

For fiscal year 1989, ACTION estimates that about 27,600 fedeally and non-federally funded foster grandparents assisted approximately 70,000 children in 262 community projects.

(3) Senior Companion Program

The Senior Companion Program (SCP) was authorized in 1973 by Public Law 93-113 and incorporated under Title II, section 211(b) of the Domestic Volunteer Service Act of 1973. The Omnibus Budget Reconciliation Act of 1981 amended section 211 of the act to create a separate Part C containing the authorization for the Senior Companion Program. This program is designed to provide part-time volunteer opportunities for low-income persons 60 years and older to assist them in providing supportive services to vulnerable, frail older persons. Like the FGP, the 1986 amendments (P.L. 99-551) amended SCP to permit non-low-income volunteers to participate without a stipend, but reimbursed for out-of-pocket expenses. The volunteers help homebound, chronically disabled older persons to maintain independent living arrangements in their own residences. Volunteers also provide services to institutionalized older persons and seniors enrolled in community health care programs. Senior companions serve 20 hours a week and receive the same stipend and benefits as foster grandparents. To participate in the program, low-income volunteers must meet the same income test as for the Foster Grandparent Program.

In fiscal year 1989, about 12,500 SCP volunteers serviced in 142 projects, including volunteers in non-federally funded projects. ACTION estimates that these volunteers served over 30,000 persons.

(B) VOLUNTEERS IN SERVICE TO AMERICA

Volunteers in Service to America (VISTA) was originally authorized in 1964, conceived as a domestic peace corps for volunteers to serve full-time in projects designed to reduce poverty. Today, VISTA still holds this mandate. Volunteers 18 years and older serve in community activities to reduce or eliminate poverty and poverty-related problems. Activities include assisting the handicapped, the homeless, the jobless, the hungry, and the illiterate or functionally illiterate. Other activities include addressing problems related to alcohol abuse and drug abuse, and assisting in economic development, remedial education, legal and employment counseling, and other activities that help communities and individuals become self-sufficient. Volunteers also serve on Indian reservations, in federally assisted migrant worker programs, and in federally assisted institutions for the mentally ill and mentally retarded.

Volunteers are expected to work full-time for a minimum of 1 year, but they may serve for up to 5 years. To the maximum extent possible, they live among and at the economic level of the people they serve. Volunteers are reimbursed for certain travel expenses and receive a subsistence allowance for food, lodging, and incidental expenses. The subsistence allowance may not be less than 95 percent of the poverty line for the area in which the volunteer is serving. They also receive health insurance and a monthly stipend not to exceed $75 ($90 in fiscal year 1991; $95 in subsequent years) that is paid in a lump sum at the end of their service. The 1989 reauthorization legislation requires that at least 20 percent of the volunteers fall into each of two age categories: (a) persons 55 years and older and (b) persons 18-27 years old.

2. ISSUES

In recent years, there has been a strong resurgence of interest in the role that volunteers can play in both the public and the private nonprofit community service delivery system. Volunteer service has been a traditional means by which individuals and organizations have helped to meet social and cultural needs in society. Historically, voluntarism has been thought of as a commitment of time and resources to institutions and organizations such as hospitals, nursing homes, shelters for the homeless and abused, schools, churches, and other social service agencies. More recently, volunteer service has included activities for grassroots political advocacy and community improvement programs. In many communities, the need to address the problems of poverty and to utilize the skills and experiences of elderly volunteers continues, notably the elderly. Despite the interest among volunteer programs to utilize elderly volunteers, there has been relatively little structured evaluation of ways to achieve this goal.

In the Domestic Volunteer Service Act Amendments of 1984 (P.L. 98-288), Congress authorized senior companion demonstration projects to explore ways in which the SCP could serve the growing population of frail homebound older persons at high risk of institutionalization. To accomplish this, SCP was authorized to recruit unpaid community volunteers to train senior companions and to use senior companion volunteer leaders (SCVLs) to assist other older persons in need. Grants were awarded to 19 new SCP projects and 17 new components of existing SCP projects at the beginning of fiscal year 1986.

In a search for public policy to meet the long-term care needs of the rapidly increasing older population, Congress mandated an evaluation of the demonstration projects, identifying five issues:

1. The extent to which the costs of providing long-term care are reduced by using SCP volunteer companions, who receive modest stipends, to assist the frail elderly living at home;
2. The effectiveness of long-term care services provided by volunteers;
3. The extent to which the health care needs and health-related costs of the volunteer companions are affected by their participation in SCP;
4. The extent of SCP project coordination with other Federal and State efforts aimed at enabling older individuals to receive care in their own homes; and
5. The effectiveness of using senior companion volunteer leaders and volunteer trainers.

The evaluation of the new projects, completed in 1988, points out that SCP services supplement and augment long-term care services from other sources, rather than replace them. Nevertheless, the projects proved to be a relatively low-cost means of providing needed services to frail older persons who generally could not afford to purchase them. However, cost containment is not the only rationale for developing long-term care policy. Improving the quality of life and well-being of the elderly are also major long-term care goals.

The value of the program to the senior companions is demonstrated by the economic benefit of the stipend and the senior companions' high degree of social integration and well-being. Senior companions generally benefit from training by volunteers. Preservice as well as in-service training is already a requirement of the Senior Companion Program. It is unclear whether the benefits of utilizing volunteer trainers differ significantly from paid staff trainers.

The position of senior companion volunteer leaders was not successfully implemented in many of the projects due to a concern among project staffs that the position created a hierarchy among the volunteers, that jeopardized senior companion relationships. Senior companions were generally found to provide informal support services for each other regardless of the presence of SCVLs. Finally, the evaluation found that the most significant impediment to matching companions and clients in the projects, urban or rural, was the lack of access to transportation, another issue to be addressed in implementing long-term care policy.

A major concern for successful continuation of the programs is the need for increased funding support for administration of the projects. Due to administrative restrictions, past cost-of-living increases for the Older Americans Volunteer Programs have resulted in an expansion of volunteer services without a corresponding increase for administrative costs. Consequently, for over 10 years, project directors have been faced with the increasingly difficult task of supervising a greater number of volunteers without additional support.

3. Congressional Response

Congress enacted the Domestic Volunteer Service Act Amendments of 1989 (P.L. 101-204). These amendments reauthorized all ACTION agency programs through 1993 and made several minor changes in existing law. Two major provisions designed to increase volunteer recruitment specifically require ACTION to establish a VISTA recruitment program and to reserve a portion of its annual budget for recruitment activities.

The 1989 amendments established the following authorization levels for older American volunteer programs through 1993: VISTA ($30.6 million, FY 1990; $39.9 million, FY 1991; $47.8 million, FY 1992; $56 million, FY 1993), RSVP $39.9 million, FY 1990; $43.9 million, FY 1991; $48.3 million, FY 1992; $53.1 million, FY 1993), Foster Grandparents Program ($70.8 million, FY 1990; $80.9 million, FY 1991; $91.7 million, FY 1992; $98.2 million, FY 1993), and the Senior Companion Program ($36.6 million, FY 1990; $39 million, FY 1991; $44.7 million, FY 1992; $48.7 million, FY 1993).

Congress increased appropriations for ACTION programs for fiscal year 1991. Appropriations for Older American Volunteer Programs are as follows: VISTA (30.3 million), RSVP ($33.4 million), Foster Grandparent Program ($62.9 million), and Senior Companion Program ($27.6 million).

Congress did not make any changes in the ACTION programs in 1990. Advocates and policymakers will continue to monitor how well ACTION implements the 1989 amendments, particularly the VISTA recruitment provisions.

D. TRANSPORTATION

1. BACKGROUND

Transportation is a vital connecting link between home and community. For the elderly and nonelderly alike, adequate transportation is necessary for the fulfillment of most basic needs—maintaining relations with friends and family, commuting to work, grocery shopping, and engaging in social and recreational activities. Housing, medical, financial, and social services are useful only to the extent that transportation can make them accessible to those in need. Transportation serves both human and economic needs. It can enrich an older person's life by expanding opportuntities for social interaction and community involvement, and it can support an individual's capacity for independent living, thus reducing or eliminating the need for institutional care.

Three strategies have marked the Federal Government's role in providing transportation services to the elderly:

(1) Direct provision (funding capital and operating costs for transit systems),

(2) Reimbursement for transportation costs, and

(3) Fare reduction.

In fiscal years 1981–89, the Reagan administration proposed to eliminate or substantially reduce Federal operating subsidies to States for transportation programs. This proposal was indicative of the trend to shift fiscal responsibility for transportation programs to the States and of a general retrenchment on the part of the Federal Government to support further transportation systems.

The major federally sponsored transportation programs that provide assistance to the elderly and handicapped are administered by the Department of Health and Human Services (HHS) and the Department of Transportation (DOT). Under HHS, a number of programs provide specialized transportation services for the elderly, including Title III of the Older Americans Act (OAA), the Social Services Block Grant Program (SSBG), the Community Services Block Grant Program (CSBG) and Medicaid, which will to a limited extent reimburse elderly poor for transportation costs to medical facilities. Under CSBG, more dollars (approximately 32 percent) are spent on so-called linkages with other programs—including transportation for the elderly and handicapped to senior centers, and community and medical services—than on any other program category.

The passage of the OAA of 1965 has had a major impact on the development of transportation for older persons. Under Title III of the act, States are required to spend an adequate proportion of their Title III–B funds on three categories: access services (transportation and other supportive services); in-home services, and legal assistance. In fiscal year 1989, approximately 2 million persons were recipients of transportation services under the OAA. Approximately 10 percent of OAA funds are used for transportation services. This level of participation and funding indicates the demand for transportation services by the elderly at the local level and the extent to which this network of supportive services provides assistance and relief to needy elderly nationwide.

The passage of the 1970 amendments to the Urban Mass Transit Act (UMTA) of 1964 (P.L. 98-453), which added section 16, marked the beginning of special efforts to plan, design, and set aside funds for the purpose of modifying transportation facilities to improve access for the elderly and handicapped. Section 16 of UMTA declares a national policy that elderly and handicapped persons have the same rights as other persons to utilize mass transportation facilities and services. Section 16 also states that special efforts shall be made in the planning and design of mass transportation facilities and services to assure the availability of mass transportation to the elderly and handicapped persons, and that all Federal programs offering assistance in the field of mass transportation should contain provisions implementing this policy. The goal of seciton 16 programs is to provide assistance in meeting the transportation needs of elderly and handicapped persons where public transportation services are unavailable, insufficient, or inappropriate. A total of $379.2 million has been obligated between fiscal years 1975 and 1989 for the purchase of specialized vehicles and equipment.

Another significant initiative was the enactment of the National Mass Transportation Assistance Act of 1974 (P.L. 93-503) which amended UMTA to provide block grants for mass transit funding in urban and nonurban areas nationwide. Under the program, block grant money can be used for capital operating purchases at the localities' discretion. The act also requires transit authorities to reduce fares by 50 percent for the elderly and handicapped during offpeak hours. In addition, passage of the Surface Transportation Assistance Act (STAA) of 1978 (P.L. 95-549) provided Federal funding, Section 18 program, which supports public transportation program costs, both operating and capital, for nonurban areas. Elderly and handicapped people in rural areas benefit significantly from section 18 projects because they generally are more isolated and in greater need of transportation assistance. Section 18 has received annual appropriations of approximately $65-$75 million since fiscal year 1979.

The STAA of 1982 (P.L. 97-424) established Section 9 in its amendments to the UMTA Act. Section 9, a block grant program, replaces the former Section 5 program (urban formula grants) and incorporates funding to continue the Section 18 program. Section 9 provides assistance to the public in general, but some of its provisions are especially important to elderly and handicapped persons. Section 9 continues the requirement that recipients of Federal mass transit assistance offer half-fares to elderly and handicapped people during nonpeak hours. Each year, between $10 and $20 million of Section 9 funds have been transferred to the Section 18 program.

Since fiscal year 1987, Congress has appropriated approximately $5 million each year for the Rural Transit Assistance Program

(RTAP) which was set up to provide training, technical assistance, research, and related support service for providers of rural public transportation. UMTA allocates 85 percent of the funds to the States to be used to develop State rural training and technical assistance programs. By the end of fiscal year 1989, all States had approved programs underway. The remaining 15 percent of the annual appropriation supports a national program, which is administered by a consortium led by the American Public Works Association and directed by an advisory board made up of local rural providers and State program administrators.

The programs administered by the Department of Health and Human Services have proven to be highly successful in providing limited supportive transportation services necessary to link needy elderly and handicapped persons to social services in urban and suburban areas. The Department of Transportation programs have been the major force behind mass transit construction nationwide and continue to provide basic funding for primary transportation services for older Americans. Recognizing, nevertheless, the overlapping of funding and services, and the need for increased coordination, HHS and DOT established an interdepartmental Coordinating Council on Human Services Transportation in 1986. The council is charged with coordinating related programs at the Federal level and promoting coordination at the State and local levels. As part of this effort, a regional demonstration project has been funded, and transportation and social services programs in all States are being encouraged to develop better mechanisms for working together to meet their transportation needs.

Despite these program initiatives, Federal strategy in transportation remains essentially limited to providing seed money for local communities to design, implement, and administer transportation systems to meet their individual needs. In the future, the increasing need for specialized services for the elderly and handicapped will dictate the range of services available and the fiscal responsibility of State and local communities to finance both large-scale mass transit systems and smaller neighborhood shuttle services.

2. Issues

(A) TRANSPORTATION AS ACCESS SERVICE

Medicare's Prospective Payment System (PPS) has placed increasing demands on transportation services. Under PPS, predetermined fixed payment rates are set for each Medicare hospital inpatient admission, based on the diagnosis related group (DRG) into which that admission falls. This fixed payment is an incentive for hospitals to limit costs spent on Medicare patients either by reducing lengths of stay or the intensity of care provided. As a result, many older persons are being released from the hospital earlier and in need of more follow-up care than before the introduction of PPS. Consequently, State and area agencies on aging now are spending more of their transportation funds to transport older persons to dialysis and chemotherapy and less for grocery store and senior center transportation. One State, Kentucky, characterizes transportation as its top priority. This State conducted a survey which found that lack of transportation is a major barrier to mental health and social support services. Of those who had difficulty attending social activity programs, 52 percent cited the lack of transportation as the reason. This barrier results in less socialization and less satisfaction with life in general. It is anticipated that the demand for transportation services will increase.

TABLE 3.—LATENT DEMAND FOR TRANSPORTATION SERVICES OF POPULATION 65 AND OVER IN 2000

	Number of nondrivers	Trips per capita per year	Total annual trips
Urban		1,734.4	
Activity limitation:			
Unable to conduct major activity	821,730		1,425,208,582
Limited in major activity	986,592		1,711,145,388
Limited but not in major activity	297,116		515,317,417
Unlimited	1,753,335		3,040,984,073
Suburban		1,734.4	
Activity limitation:			
Unable to conduct major activity	1,211,704		2,101,578,756
Limited in major activity	1,454,805		2,523,214,312
Limited but not in major activity	438,120		759,874,835
Unlimited	2,585,426		4,484,162,956
Rural		1,679.3	
Activity limitation:			
Unable to conduct major activity	1,058,500		1,777,538,568
Limited in major activity	1,270,864		2,134,162,587
Limited but not in major activity	382,725		642,710,544
Unlimited	2,258,533		3,792,754,649
Total number of trips taken because of lack of transportation			24,908,652,616

The lack of adequate transportation to social activities, the grocery store and the doctor can have serious consequences for the well-being and independence of many elderly. It also may set back some of the advancements in health that have been achieved through better access to services.

(B) RURAL TRANSPORTATION NEEDS

Generally, Federal transportation policy has not recognized the specialized needs of rural elderly. Specific recommendations were made during the 1971 White House Conference on Aging directed at improving transportation for the rural elderly. A miniconference on transportation for the aging, which preceded the general conference, recommended that State transportation agencies play a central role in developing responsive rural systems, and that implementation of such systems be initiated at the local level. The Conference also recommended greater citizen participation at the policymaking level, as well as at the advisory and implementation levels of transportation programs.

Transportation was cited as one of the major barriers facing the rural elderly in a 1984 report published by the Senate Special Committee on Aging. According to the report, an estimated 7 million to 9 million rural elderly lack adequate transportation, and as a result, are severely limited in their ability to reach needed services. Lack of transportation for the rural elderly stems from several factors. First, the dispersion of rural populations over relatively large areas complicates the design of a cost-effective, efficient public transit system. In addition, the incomes of the rural elderly generally are insufficient to afford the high fares necessary to support a rural transit system. Also, the rising cost of operating vehicles and inadequate reimbursement have contributed to the decline in the numbers of volunteers willing to transport the rural elderly. Further, the physical design and service features of public transportation, such as high steps, narrow seating, and unreliable scheduling, discourage participation.

Lack of access to transportation in rural areas leads to an underutilization of programs specifically designed to serve older persons, such as adult education, congregate meal programs, and health promotion activities. Thus, the problems of service delivery to rural elderly are essentially problems of accessibility rather than program design.

In August 1990, the Special Committee on Aging conducted a field hearing a Little Rock, AR. The hearing, chaired by Senator David Pryor (D-Ark.), addressed a number of long-term care issues, including the transportation programs under Title III of the Older Americans Act. The hearing further highlighted the need for senior transportation services, particularly in rural communities.

(C) SUBURBAN TRANSPORTATION NEEDS

The graying of the suburbs is a phenomenon that has only recently received attention from policymakers in the aging field. Since their growth following World War II, it has been assumed that the suburbs consisted mainly of young, upwardly mobile families. The decades that have since elapsed have changed entirely the profile of the average American suburb, resulting in profound implications for social service design and delivery. In 1980, for the first time, a greater number of persons over age 65 lived in the suburbs (10.1 million) than in central cities (8.1 million).

This aging of suburbia can be attributed to two major factors. First, migration has contributed to the growth of the older suburban population. It is estimated that for every person age 65 and older who moves back to the central city, three move from the central city to the suburbs. Second, many older persons desire to remain in the homes and neighborhoods in which they have grown old, i.e., "aging in place." The growth of the suburban elderly population is expected to continue to increase at an even more rapid in the future due to the large number of so-called pre-elderly (ages 50–64) living in the suburbs.

A 1988 national study conducted by the U.S. Conference of Mayors (USCM) and the National Association of Counties (NACo) of the 260 metropolitan statistical areas identified three priority concerns of the suburban elderly: home and community-based care, housing, and transportation. The availability of transportation services for the elderly suburban dweller is limited. Unlike large cities where dense population patterns can facilitate central transit systems, the lack of a central downtown precludes development of a coordinated mass transit system in most suburbs. The sprawling geographical nature of suburbs makes the cost of developing and operating mass transportation systems prohibitive. Private taxi companies, if they operate in the outlying suburban areas at all, are usually very expensive. Further, the trend toward retrenchment and fiscal restraint by the Federal Government has impacted significantly on the development of transportation services. Consequently, Federal support for primary transit systems designed especially for the elderly suburban dweller is almost nonexistent. State and local governments have been unable to harness sufficient resources to fund costly transportation systems independent of Federal support. Alternative revenue sources, such as user fees, are insufficient alone to support suburbanwide services and are generally viewed as penalizing those most in need of transportation services in the community—the elderly poor.

The aging of the suburbs has several implications for transportation policy and the elderly. The dispersion of older persons over a suburban landscape poses a challenge for community planners who have specialized in providing services to younger, more mobile dwellers. Transportation to and from service providers is a critical need. Institutions that serve the needs of elderly persons, such as hospitals, senior centers, and convenience stores, must be designed with supportive transportation services in mind. In addition, service providers must provide transportation services for their elderly clients. Primary transportation systems, or mass transit, must ensure accessibility from all perimeters of the suburban community to adequately serve the dispersed elderly population. The demand for transportation services should be measured to determine the feasibility of alternative systems, such as dial-a-ride and van pools. Alternative funding mechanisms, such as reduced fares, user fees, and the local tax base, need to be examined for equity and viability. Also, the public should be informed of the transportation services available through a coordinated public information network within the community.

The aging suburb trend will increase in the decades to come. It is clear that to the extent that the elderly are denied access to transportation, they are denied access to social services. If community services are to meet the growing social and economic needs for the older suburban dweller, transportation planning and priorities will demand re-examination.

(D) SAFETY

The automobile remains the primary means of transportation for the entire country, including older persons. More than 80 percent of trips by persons age 65 and over are made in automobiles and that percentage is increasing.

A 1988 study by the Transportation Research Board (TRB) on the mobility and safety of older drivers found that up through age 75, most older drivers have good driving records and appear to perform as well as middle-aged drivers. However, although they are involved in a small number of crashes, after age 75, older drivers are about twice as likely to be involved in a crash per mile driven. In addition, older persons are among the most vulnerable to injury in motor vehicle crashes. Automobile occupants age 65 and older are more than three times as likely to die than a 20-year-old occupant from injuries of equal severity. The study emphasizes that because age is not a predictor of performance, it should not be the basis for restricting or withholding driver's licenses.

The TRB report does recommend changes in roadway design and operation to improve the safety of not only older, but all drivers. For example, current sign legibility standards assume a level of visual ability that many older persons cannot meet. Safety could be enhanced by larger and brighter road signs.

With the increasing number of older drivers on the roads, several States are examining ways to improve the automobile traffic system. In California, for example, the Department of Motor Vehicles has begun planning for new night and peripheral vision tests, video simulation exercises, and longer, more complex written examinations. Although couched as the State's effort to assure competence of all drivers, and not just the elderly, aging advocates are monitoring the proposed changes for signs of illegal age discrimination.

Walking is second in importance to driving as a mode of transportation for older persons. For those older persons without driver licenses, between 20 and 40 percent of all their trips are made by walking. Yet many suburban environments do not provide for safe walking—pedestrian crossings are frequently not available and signals are often set to maintain a high volume of auto traffic. In addition, signal timing assumes a walking speed faster than that of many older pedestrians.

3. Federal and State Responses

(A) FEDERAL

In 1990, there were significant developments in transportation programs affecting the elderly and disabled. The passage of the Americans with Disabilities Act (ADA) in July places additional responsibilities on Section 18 agencies, both private nonprofit or public. These agencies are now required to accommodate the needs of the disabled. In addition, the regulation includes private for-profit companies under contract to provide Section 18 services.

The appropriations bill for fiscal year 1991 (P.L. 101-516) appropriated $35 million for elderly and handicapped projects, and innovative research programs, authorized under the Federal Mass Transportation Act of 1987.

1991 marks the reauthorization of UMTA as well as OAA. Advocates and policy makers over poised to address the increasing need and demand for transportation service for older Americans.

(B) STATES

As an indication of concern about transportation issues, the Council of State Governments created the Center for Transportation in 1986 to function as a State policy research think-tank. A survey by the Center reveals that at least 40 States have responded to the issue of coordination of locally designed services by creating either voluntary or legislatively mandated interagency coordination committees. In addition, nine States impose mandatory coordination on local providers.

Montana, for example, has developed a coordinated interagency approach for purchasing vehicles. As the lead agency, the Department of Commerce works to ensure that vehicles are shared by those agencies that need them at the local level. Local technical advisory committees also review and recommend transportation providers and purchasers of services in the community, including the area agencies on aging. In Florida, the Coordinating Council for the Transportation Disadvantaged oversees and develops transportation policy affecting about 4 million elderly, low-income and handicapped residents who need transportation assistance. Approximately $41 million is being spent for these services in all 67 counties of the State. Each county has designated a single provider to coordinate these services.

E. LEGAL SERVICES

1. BACKGROUND

(A) THE LEGAL SERVICES CORPORATION

Legislation creating the Legal Services Corporation (LSC) (Corporation) was enacted in 1974. Previously, legal services had been a program of the Office of Economic Opportunity, added to the Economic Opportunity Act in 1966. Because litigation initiated by legal services attorneys often involves local and State governments or controversial social issues, legal services programs can be subject to unusually strong political pressures. In 1971, in an effort to insulate the program from those political pressures, the Nixon administration developed legislation creating a separate, independently housed corporation. The Legal Services Program was then established as a private, nonprofit corporation headed by an 11 member board of directors, nominated by the President and confirmed by the Senate.

The Corporation does not provide legal services directly. Rather, it funds local legal aid projects. Each local legal service project is headed by a board of directors, of whom 60 percent are lawyers admitted to a State bar.

Legal services provided through Corporation funds are available only in civil matters and to any individual with an income no higher than 125 percent of the Office of Management and Budget poverty line. The Corporation places primary emphasis on the provision of routine legal services and the majority of LSC-funded activities involve routine problems of low-income people. According to the most recent report of the Corporation, in 1989, almost 31 percent of legal services cases are family related, such as divorce and separation, child custody and support, and adoption. Another 21 percent of legal services cases deal with housing problems, primarily landlord-tenant disputes in nongovernment subsidized housing. Problems with welfare or other income maintenance programs, and consumer and finance problems, form the next two largest categories of legal services cases. Individual rights, employment, health, juvenile, and education cases make up the remaining case load. Most cases are resolved outside the courtroom. LSC attorneys do their primary representation of the elderly in government benefit programs such as Social Security and Medicare.

The Corporation funds 23 national and State support centers, which provide specialized expertise in various aspects of poverty law. Three of these centers are specifically involved in issues that confront older people: the National Senior Citizens Law Centers, in Los Angeles and Washington, DC; and Legal Counsel for the Elderly, in Washington, DC. In addition, LSC currently is funding 20 law school clinical programs to assist eligible clients during the academic year 1989–90. Two of these programs focus exclusively on the elderly.

Several restrictions on the types of cases legal services attorneys may handle were included in the original law and several other restrictions have since been added. Most of the restrictions were made in response to critics of the program who charge that legal services funds have been used to promote the social and political goals of activist attorneys. Opponents believe that although legal services attorneys are prohibited from pursuing their own political and social interests, this requirement is easily circumvented. Current regulations include a prohibition on cases dealing with school desegregation, nontherapeutic abortions, certain violations of the Selective Service Act, and Armed Forces desertion. The fiscal year 1987 appropriations measures (P.L. 99–500 and P.L. 99–591) contained additional prohibitions against lobbying with Corporation funds, representing aliens who do not meet specified conditions, and class action suits against Federal, State, or local governments except under certain circumstances.

Other restrictions were promoted by supporters of legal services who were concerned that the broad scope of the Corporation's work would be curtained by its opponents. For example, the 1987 appropriations measures require prior notification of Congress when regulations are to be promulgated. This notification requirement was added in response to concerns that proposed regulations issued by the LSC, such as those curtailing legislative and administrative advocacy by LSC attorneys on behalf of poor clients, would drastically change existing Corporation policy.

In the fiscal year 1991 appropriations measure (P.L. 101–515), Congress retained all prior restrictions on LSC.

(B) OLDER AMERICANS ACT

Support for legal services under the Older American Act (OAA) was a subject of interest to both the Congress and the Administration on Aging (AoA) for several years preceding the 1973 amendments to the OAA. There was no specific reference to legal services in the initial version of the OAA in 1965, but recommendations concerning legal services were made at the 1971 White House Conference on Aging. Regulations promulgated by the AoA in 1973 made legal services eligible for funding under Title III of the OAA. Subsequent reauthorizations of the OAA contained provisions relating to legal services. In 1975, amendments granted legal services priority status. Amendments to the OAA, in 1978, established a funding mechanism and a program structure for legal services. The 1981 amendments required that area agencies on aging spend "an adequate proportion" of social service funding for three categories, including legal services, as well as access and in-home services, and that "some funds" be expended for each service. The 1984 amendments to the Act retained the priority, but changed the term to "legal assistance," and required that an "adequate proportion" be spent on "each" priority service. In addition, area agencies were to annually document funds expended for this assistance.

A survey by the Center for Social Gerontology in Michigan conducted prior to the 1987 reauthorization of the Act found that 40 States had no specific policy or definition of "adequate proportion" for each of the priority services. Consequently, the 1987 amendments specified that each State unit on aging must designate a "minimum percentage" of Title III social services funds that area agencies on aging must devote to legal assistance and the other two priority services. If an area agency expends at least the minimum percentage set by the State, it will fulfill the adequate proportion requirement. Congress intended the minimum percentage to be a floor, not a ceiling, and has encouraged area agencies to devote additional funds to each of these service areas to meet local needs.

In addition, the Act also requires area agencies to contract with legal services providers experienced in delivering legal assistance and to involve the private bar in their efforts. If the legal assistance grant recipient is not a Legal Service Corporation grantee, coordination with LSC-funded programs is required.

Another mandate under the OAA requires State agencies on aging to establish and operate a long-term care ombudsman program to investigate and resolve complaints made by or on behalf of residents of long-term care facilities. The 1981 amendments to the OAA expanded the scope of the ombudsman program to include board and care facilities. The 1987 amendments require States to ensure ombudsmen protection from liability, willful interference, and retaliation in the good faith performance of their duties. In many States and localities, there is a close and mutually supportive relationship between State and local ombudsman programs and legal services programs.

The AoA has stressed the importance of such a relationship and has provided grants to States designed to further ombudsman, legal, and protective services activities for older people and to assure coordination of these activities. State ombudsman reports and a survey by the AARP conducted in 1987 indicate that through formal and informal agreements, legal services attorneys and paralegals help ombudsmen secure access to the records of residents and facilities; provide consultation to ombudsman on law and regulations affecting institutionalized persons; represent clients referred by ombudsman programs, and work with ombudsmen and others to change policies, laws, and regulations that benefit older persons in institutions.

In other initiatives under the OAA, the Administration on Aging began in 1976 to fund State legal services developer positions—attorneys, paralegals, or lay advocates—through each State unit on aging. These specialists work in each State to identify interested participants, locate funding, initiate training programs, and assist in designing projects. They work with legal services offices, bar associations, private attorneys, paralegals, elderly organizations, law firms, attorney generals, and law schools.

In addition, the 1984 amendments also mandated that AoA fund national legal support centers. In fiscal year 1990, AoA awarded funds for legal services to support the following organizations: the National Senior Citizens Law Center; Legal Counsel for the Elderly (sponsored by the AARP); the ABA's Commission on Legal Problems of the Elderly; the Center for Social Gerontology; the Pension Rights Center; the National Clearinghouse for Legal Services, Inc.; the Mental Health Law Project; and the National Bar Association.

Today, OAA funds support over 600 legal programs for the elderly in greatest social and economic need. The 1987 amendments to OAA required that beginning in fiscal year 1989, the Commissioner collect data on the funds expended on each type of service, the number of persons who receive such services, and the number of units of services provided. For fiscal year 1989, AoA data show that $16.4 million of Title III funds were expended on legal services, serving approximately 305,000 persons.

(C) SOCIAL SERVICES BLOCK GRANT

Under the block grant program, Federal funds are allocated to States which, in turn, either provide services directly or contract with public and nonprofit social service agencies to provide social services to individuals and families. In general, States determine the type of social services to provide and for whom they shall be provided. Services may include legal aid. Because the Omnibus Budget Reconciliation Act of 1981 eliminated much of the reporting requirements previously included in the Title XX program, little information is available on how States have responded to both funding reductions and changes in the legislation. As a result, there is little information available on the number and ages of persons being served.

2. ISSUES

(A) NEED AND AVAILABILITY OF LEGAL SERVICES

The need for civil legal services for the elderly, especially the poor elderly, is undeniable. This is partially due to the complex nature of the programs upon which the elderly are dependent. After retirement, most older Americans rely on Government-adminstered benefits and services for their entire income and livelihood. For example, many elderly persons rely on the Social Security program for income security and on the Medicare and Medicaid programs to meet their health care needs. These benefit programs are extremely complicated and often difficult to understand.

In addition to problems with government benefits, older persons' legal problems typically relate to consumer fraud, property tax exemptions, special property tax assessments, guardianships, involuntary commitment to institutions, nursing home and probate matters. Legal representation is often necessary to help the elderly obtain basic necessities and to assure that they receive benefits and services to which they are entitled.

Legal Services Corporation programs do not necessarily specialize in serving older clients but attempt to meet the legal needs of the poor, many of whom are elderly. Legal services are provided to people based on financial need. Eligibility is based on income up to 125 percent of the established poverty level. It is estimated that approximately 9 million persons over 60 are LSC-eligible.

There is no precise way of determining eligibility for legal services under the OAA because eligibility is based on economic and social need, but means testing for eligibility is prohibited. Nevertheless, a paper developed by several legal support centers in 1987 demonstrated that in spite of advances in the previous 10 years, the need for legal assistance among older persons is much greater than available OAA resources can meet.

The availability of legal representation for low-income older persons is determined, in part, by the availability of funding for legal services programs. In recent years, there has been a trend to cut Federal dollars to local programs that provide legal services to the elderly. There is no doubt that older persons are finding it more difficult to obtain legal assistance. When the LSC was established in 1975, its foremost goal was to provide all low-income people with at least "minimum access" to legal services. This was defined as the equivalent of 2 legal services attorneys for every 10,000 poor people. The goal of minimum access was achieved in fiscal year 1980 with an appropriation of $300 million, and in fiscal year 1981, with $321 million. This level of funding met only an estimated 20 percent of the poor's legal needs. Currently, the LSC is not even funded to provide minimum access. In most States, there is only 1 attorney for every 10,000 poor persons. In contrast, there are approximately 28 lawyers for every 10,000 persons above the Federal poverty line.

The Private Attorney Involvement (PAI) project under LSC requires each LSC grantee to spend at least 12.5 percent of its basic field grant to promote the direct delivery of legal services by private attorneys, as opposed to LSC staff attorneys. The funds have been primarily used to develop pro bono panels, with joint sponsorship between a local bar association and a LSC grantee. Over 350 programs currently exist throughout the country. Data indicates that the PAI requirement is an effective means of leveraging funds. A higher percentage of cases were closed per $10,000 of PAI dollars than with dollars spent supporting staff attorneys.

It should be noted, however, that these programs have been criticized by legal services staff attorneys. They claim that they have been unjustifiably cited to support less LSC funding and to the diversion of cases from LSC field offices.

In fiscal year 1982, Congress reduced funding to the LSC by 25 percent (from $321 million to $241 million), resulting in the immediate loss of 1,793 attorneys and the closing of more than 108 local offices. This make it even more difficult for older persons to gain access to legal representation. In fiscal year 1988, there were 324 legal services programs in the 50 States, the District of Columbia, the Virgin Islands, Puerto Rico, Micronesia, and Guam. The number of field program offices in 1988 was approximately 1,150, down from 1,475 in 1981. At the end of 1987, the LSC employed 4,767 attorneys, as compared to 6,559 in 1980.

LSC programs handled and closed 1,439,048 cases in calendar year 1989. About 12 percent of the cases handled in 1989 involved a client age 60 or older.

Cuts in funding have decreased the LSC's ability to meet clients' legal needs. Legal services field offices report that they have had to scale down their operations and narrow their priorities to focus attention on emergency cases, such as evictions or loss of means of support. Legal services offices must now make hard choices about who to serve.

The private bar is an essential component of the legal services delivery system for the elderly. The expertise of the private bar is considered especially important in areas such as wills and estates as well as real estate and tax planning. Many elderly persons, however, cannot obtain legal services because they cannot afford to pay customary legal fees. In addition, a substantial portion of the legal problems of the elderly stem from their dependence on public benefit programs. The private bar generally is unable to undertake representation in these matters because it requires familiarity with a complex body of law and regulations, and there is little chance of collecting a fee for services provided. Although many have cited the capacity of the private bar to meet some of the legal needs of the elderly on a full-fee, low-fee, or no-fee basis, the potential of the private bar has yet to be fully realized.

(B) LEGAL SERVICES CORPORATION

(1) Board Appointments

During the Reagan administration, there was continuing conflict between the White House and the Congress over appointees to the LSC's board of directors. During the summer of 1981, the terms of all 11 LSC board members appointed by former President Carter expired. President Reagan, however, did not name any new members of the board until December 1981, after it became apparent that his proposal to terminate the Corporation would not be accepted. Between 1981 and 1984, he nominated a succession of people to the board on an interim basis. Because these appointments were made while Congress was in recess, they were able to serve without Senate confirmation. During the same period, President Reagan announced a number of prospective nominees, but none was confirmed by the Senate. Some nominees were opposed by liberals and moderates who questioned their qualifications and their commitment to legal services for the poor. Reports in 1982 that LSC board members were receiving extraordinarily large consulting fees for their services and that the LSC president was given unusually generous fringe benefits further affected the nomination process. In 1984, President Reagan granted recess appointments to 11 individuals he had unsuccessfully nominated earlier in the year. These people served without Senate confirmation until the end of 1985. Although a couple of the nominees were controversial and faced stiff opposition, all were approved by the Senate Labor and Human Resources Committee and subsequently by the full Senate on June 12, 1985.

In January 1990, President Bush replaced 9 LSC board members who remained from the Reagan administration, bringing the total to 11, including 2 members he had previously appointed in December of 1989. As recess appointees, their names were sent to the Senate as nominees for confirmation. The 101st Congress, however, failed to confirm the nominees and their terms expired. It is expected that President Bush will reappoint all of the 1990 LSC board members for 1991.

(2) Status of Legal Services Corporation

Few people disagree that provision of legal services to the elderly is important and necessary. However, people continue to debate how to best provide these services. In 1981, President Reagan proposed to terminate the federally funded LSC and to include legal services activities in a social services block grant. Funds then provided to the Corporation, however, were not included. This block grant approach was consistent with the Reagan administration's goal of consolidating categorical grant programs and transferring decisionmaking authority to the States. Inclusion of legal services as an eligible activity in block grants, it was argued, would give States greater flexibility to target funds where the need is greatest and allow States to make funding decisions regarding legal services would make the program accountable to elected officials.

At the time of this proposal, the Reagan administration revived earlier charges that legal services attorneys are more devoted to social activism and to seeking collective solutions and reform than to routine legal assistance for low-income individuals. These charges resparked a controversy surrounding the program at the time of its inception as to whether Federal legal aid is being misused to promote liberal political causes. The poor often share common interests as a class, and many of their problems are institutional in nature, requiring institutional change. Because legal resources for the poor are a scarce commodity, legal services programs have often taken group-oriented case selection and litigation strategies as the most efficient way to vindicate rights. The use of class action suits against the government and businesses to enforce poor peoples' rights has angered some officials. Others protest the use of class action suits on the basis that the poor can be protected only by procedures that treat each poor person as a unique individual, not by procedures which weigh group impact. As a result of these charges, the ability of legal services attorneys to bring class action suits has been severely restricted.

Former President Reagan also justified his proposal to terminate the LSC by stating his belief that added pro bono efforts by private attorneys could substantially augment legal services funding provided by the block grant. The administration noted that elimination of restrictions on advertising by attorneys would increase the availability of low-cost legal services. They pointed to a congressionally mandated study which found that legal services provided by private attorneys were as effective as those provided by staff attorneys hired directly by local legal services programs. Their approach would allow states to choose among a variety of services delivery mechanisms, including reimbursement to private attorneys, rather than almost exclusive use of full-time staff attorneys supported by the Corporation. Finally, the administration argued that regardless of the continued existence of LSC, some funding is available at the State and local level for civil legal assistance to truly needy individuals.

The Chairman of the Board of Directors of LSC, in a speech before the ABA's Board of Governors in 1987, also called for the elimination of the LSC. In its place he suggested a system of lay advocates to deliver services to the poor. He maintained that bar associations, motivated by self-interest, prevent more widespread use of paraprofessionals and lay advocates. Opponents of this proposition, including Members of Congress, point to the founding principle of the LSC that the poor should have access to professional legal services provided by attorneys.

Supporters of federally funded legal services programs argue that neither State nor local governments nor the private bar would be able to fill the gap in services that would be created by the abolition of the LSC. They cite the inherent conflict of interest and the State's traditional nonrole in civil legal services which, they say, makes it unlikely that States will provide effective legal services to the poor. Many feel that the voluntary efforts of private attorneys cannot be relied on, especially when more lucrative work beckons. They believe that private lawyers have limited desire and ability to do volunteer work. Some feel that, in contrast to the LSC lawyers who have expertise in poverty law, private lawyers are less likely to have this experience or the interest in dealing with the types of problems that poor people encounter.

Defenders of LSC say that the need among low-income people for civil legal assistance exceeds the levels of services currently provided by both the Corporation and the private bar. Elimination of the Corporation and its funding could further impair the need and the right of poor people to have access to their government and the justice system. They contend that it is also inconsistent to assure low-income people representation in criminal matters, but not in civil cases.

In 1990, President Bush made few public statements regarding the LSC. However, he included $317 million for the LSC in his fiscal year 1991 budget request and he appointed a new board.

(3) Status of Support Centers

The Reagan administration also attempted to cut funds to the national and State legal services support centers, as well as funds for computer assisted legal research, the clearinghouse, and the network of programs designed to aid migrant workers.

At a meeting in October 1987, the LSC Board approved 6 to 5 a motion for the cutoff. In the Senate, an effort was made to implement LSC's intent in the form of an amendment to the appropriations continuing resolution. However, the Senate viewed the LSC proposal as an attempt to change the structure of the Corporation by instituting in its place a voucher system, and soundly defeated the proposed amendment by a 70-28 vote. It was pointed out during Senate debate that the 17 national support center staffs provide the only in-depth coverage of issues of special importance to poor people—affordable health care and housing, Social Security, consumer problems, welfare, and employment—and that they are expert in interpreting of regulations, statutes, administrative and legislative procedures in these areas.

In 1988, former President Reagan, in an appendix to his State of the Union message to Congress, stated his support of actions that ensure that grantees are involved in individual cases and not broader "law reform" activities. The administration did not request any funding for support centers although, for the first time, it did request some funding for LSC. The Corporation, in a revised budget request to match that of the administration's, justified eliminating the support centers to guarantee local control of limited LSC funds.

In a survey of legal services program directors conducted by the LSC, 90 percent urged the continuation of national support centers rather than a proportional increase in their own program funding. The $7.2 million that fund national support centers would provide less than a 3-percent increase for each field program, an increase so small that it would not fill the gap that would be created by the loss of specialized assistance.

(4) Lobbying

In 1988, a dispute arose over the use of LSC funds for the purpose of lobbying Congress. Former President Reagan, for the first time during his administration, requested funding for the LSC for fiscal year 1989 at an amount lower than the fiscal year 1988 appropriation. Although the Corporation had initially requested the same funding as it had in fiscal year 1988, the Board of Directors, in a 6 to 5 vote, decreased its budget request to match that of the administration.

The Corporation then briefly engaged the services of three Washington law firms to lobby Congress for the decrease. An immediate outcry from Congress led the Corporation to rescind its agreements with the law firms, although the Chairman of the Board of Directors of LSC maintained that the prohibition on lobbying Congress by LSC did not apply to law firms retained by the LSC. An opinion by the Comptroller General on the issue, however, held that the retention of law firms to influence Congress to reduce LSC's appropriations is contrary to the law. A resolution was introduced in the Senate calling for the Corporation chairman's resignation. Bitterness over LSC lobbying continues to linger in Congress.

3. Federal and Private Sector Response

(A) LEGISLATION

(1) The Legal Services Corporation

The 1974 LSC Act was reauthorized for the first and only time in 1977 for an additional 3 years. At that time, much of the controversy surrounding the program, which grew from a perception that the program promoted social activism and reform rather than routine legal assistance, had abated. Since the early 1980's, however, the controversy as to whether Federal legal aid money is being misused to promote liberal political causes has re-emerged. This is due, in part, to the fact that for fiscal years 1981–88, the Reagan administration announced plans not to seek reauthorization of the program and requested no funding for it. Congress, however, rejected these proposals and responded with bipartisan support to restore funding.

Funding for the LSC in its first year was $92.3 million. It rose to its highest level of $321.3 million in fiscal year 1981. In fiscal year 1982, funding for the Corporation was cut by 25 percent to $241 million. Since then, funding for LSC has been at a reduced level.

Although former President Reagan requested no funding for the LSC for fiscal years 1981–88 and the legislation authorizing the LSC expired at the end of fiscal year 1980, the agency has operated under a series of continuing resolutions and appropriations bills, which have served both as authorizing and funding legislation. The Corporation is allowed to submit its own funding requests to Congress. In fiscal year 1985, Congress began to earmark the funding levels for certain activities to ensure that congressional recommendations were carried out. In addition to original restrictions, the legislation for fiscal year 1987 included language that provided that the legislative and administrative advocacy provisions in previous appropriations bills and the Legal Services Corporation Act of 1974, as amended, shall be the only valid law governing lobbying and shall be enforced without regulations. This language was included because the Corporation published proposed regulations that were believed to go far beyond the restrictions on lobbying which are contained in the LSC statute.

For fiscal year 1988, Congress appropriated $305.5 million for the LSC. Congress also directed the Corporation to submit plans and proposals for the use of funding at the same time it submits its budget request to Congress. This was deemed necessary because the appropriations committees had encountered great difficulty in tracing the funding activities of the Corporation and received very little detail from the Corporation about its proposed use of the funding request, despite repeated requests for this information.

The fiscal year 1988 appropriations bill also included a legislative formula governing the allocation of funds for grants and contracts among the basic field programs. In addition, the Corporation is prohibited from imposing requirements on the governing bodies of recipients of LSC grants that are additional to, or more restrictive than, provisions already in the LSC statute. This provision applies to the procedures of appointment, including the political affiliation and length of terms of office, and the size, quorum requirements, and committee operations of the governing bodies.

Congress appropriated $327 million for LSC in fiscal year 1991, earmarking over $280 million for basic field programs and $7.4 million for national support centers. Provisions effective in fiscal year 1991 that are continued from past years' appropriations include restrictions on lobbying, class action suits, representation of aliens, language requiring prior notification of the Congress when regulations are to be promulgated. Restrictions concerning governing bodies of recipient programs and LSC enforcement of legislative and administrative advocacy containment will expire upon confirmation by the Senate of a Board of Directors who are nominated by President Bush.

In 1990, Reps. Bill McCollum (R–Fla.), Harley O. Staggers Jr. (D–W.Va.), and Charles W. Stenholm (D–Texas) introduced a LSC "reform package" (H.R. 5336) which would have prohibited legal services programs from being awarded attorneys fees, required competitive bidding for all LSC grants, and limited access of migrant workers to legal services. Bipartisan opposition to the amendment emerged during its authors' attempts to attach the proposal to LSC reauthorization and appropriations bills. Both attempts were unsuccessful. In addition, the American Bar Association, as well as over 100 State and local bar association and foundations took formal positions against the amendment. Although settled for 1990, sponsors of the amendment intend to attach the amendment to LSC reauthorization legislation in the 102d Congress. The Senate has made no effort to restrict this action.

(2) Older Americans Act

In response to prior conflict between legal assistance providers and area agency staff over confidentiality and reporting, the 1987 amendments to the OAA (P.L. 100-175) specifically provided that state and area agencies may not require Title III legal providers to reveal information that is protected by the attorney-client privilege.

The OAA 1987 amendments also required the State agency to establish a minimum percentage of Title III-B funds that each area agency must spend on legal services. In addition, prior to granting a waiver of this requirement, the State agency must provide a 30-day notice period during which individuals or providers may request a hearing, and must offer the opportunity for a hearing to any individual or provider who makes such a request. The conference report on OAA amendments states that the minimum percentage is intended to be a floor, not a ceiling. Area agencies on aging are encouraged to devote individual funds to legal services, as well as access and in-home services, to meet local needs.

In conducting a series of legislative workshops on the reauthorization of the Senate Special Committee on Aging focused in part on legal assistance under OAA. With the reauthorization of the Act scheduled for 1991, the issue of OAA-funded legal assistance is ripe for congressional action.

(B) ACTIVITIES OF THE PRIVATE BAR

To counter the effects of cuts in Federal legal services and to ease the pressure on overburdened legal services agencies, some law firms and corporate legal departments have begun to devote more of their time to the poor on a pro bono basis. These programs are in conformity with the lawyer's code of professional responsibility which requires every lawyer to support the provision of legal services to the disadvantaged. While such programs are gaining momentum, there is no precise way to determine the number of lawyers actually involved in the volunteer work, the number of hours donated, and the number of clients served. Most lawyers for the poor say that these efforts are not yet enough to fill the gap and that a more intensive organized effort is needed to motivate and find volunteer attorneys.

A recent development in the delivery of legal services by the private bar has been the introduction of the Interest on Lawyers' Trust Accounts (IOLTA) program. This program allows attorneys to pool client trust deposits in interest bearing accounts. The interest generated from these accounts is then channeled to federally funded, bar affiliated, and private and nonprofit legal services providers. IOLTA programs have grown rapidly. There was one operational program in 1983. Today 47 States and the District of Columbia have adopted IOLTA programs that are bringing in funds at a rate of $42 million per year. The LSC reported receiving $36 million through IOLTA in 1989. An ABA study group estimated that if the plan was adopted on a nationwide basis, it could produce up to $100 million a year. The California IOLTA program specifically allocates funds to those programs serving the elderly. Although many of the IOLTA programs are voluntary, the ABA passed a resolution at its February 1988 meeting suggesting that IOLTA programs be mandatory to raise funds for charitable purposes.

Supporters of the IOLTA concept believe that there is no cost to anyone with the exception of banks, which participate voluntarily. Critics of the plan contend that it is an unconstitutional misuse of the money of a paying client who is not ordinarily apprised of how the money is spent. Supporters point out that attorneys and law firms have traditionally pooled their client trust funds, and it is difficult to attribute interest to any given client. Prior to IOLTA, the banks have been the primary beneficiaries of the income. While there is no unanimity at this time among lawyers regarding IOLTA, the program appears to have value as a funding alternative.

In 1977, the president of the ABA was determined to add the concerns of senior citizens to the ABA's roster of public service priorities. He designated a task force to examine the status of legal problems and the needs confronting the elderly and to determine what role the ABA could play. Based on a recommendation of the task force, an interdisciplinary Commission on Legal Problems of the Elderly was established by the ABA in 1979. The Commission is charged with examining six priority areas: the delivery of legal services to the elderly; age discrimination; simplification of administrative procedures affecting the elderly; long-term care; Social Security; and housing. Since 1976, the ABA Young Lawyers Division has had a Committee on the Delivery of Legal Services to the Elderly.

The Commission has undertaken many activities to promote the development of legal resources for older persons and to involve the private bar in responding to the needs of the aged. One such activity was a national bar activation project, which provided technical assistance to State and local bar associations, law firms, corporate counsel, legal service projects, the aging network, and others in developing projects for older persons.

The private bar has also responded to the needs of elderly persons in new ways on the State and local levels. Currently, there are 35 State and 12 local bar association committees on the elderly. Their activities range from legislative advocacy on behalf of seniors and sponsoring pro bono legal services for elderly people, to providing community legal education for seniors. Nearly 50 State and local projects utilize private attorneys to represent elderly clients on a reduced fee or pro bono basis. In more than 38 States, handbooks that detail seniors' legal rights have been produced either by State and area agencies on aging, legal services offices, or bar committees. In addition, some bar associations sponsor telephone legal advice lines. Since 1982, attorneys in more than half the States have had an opportunity to attend continuing legal education seminars regarding issues affecting elderly people. The emergence of training options for attorneys that focus on financial planning for disability and long-term care are particularly noteworthy.

In 1987, the Academy of Elder Law Attorneys was formed. The purpose of this organization is to assist attorneys advising elderly clients, to promote high technical and ethical standards, and to develop awareness of issues affecting the elderly.

A few corporate law departments also have begun to provide legal assistance to the elderly. For example, Aetna Life and Casualty developed a pro bono, legal assistance to the elderly program in 1981 through which its attorneys are granted up to 4 hours a week of time to provide legal help for eligible older persons. In 1987, 20 Aetna attorneys participated in the programs, handling over 140 cases. The Ford Motor Co. Office of the General Counsel began a project in 1986 to provide pro bono representation to clients referred by the Detroit Senior Citizens Legal Aid Project.

As recognized by the ABA, private bar efforts alone fall far short in providing for the legal needs of older Americans. The ABA has consistently maintained that the most effective approach for providing adequate legal representation and advice to needy older persons is thorugh the combined efforts of a continuing LSC, an effective OAA program, and the private bar. With increased emphasis on private bar involvement, and with the necessity of leveraging resources, the opportunity to design more comprehensive legal services programs for the elderly exists.

F. PROGNOSIS

Despite Federal funding cutbacks, States will continue to spend as much of their block grant funds on social services for older persons as feasible. However, these expenditures will focus increasingly on emergency services rather than on coordinated long-term services. States will find it increasingly necessary to utilize multiple funding sources to support their programs for the elderly. The lack of data on how the funds are used may require reinstituting a reporting system.

The Stewart B. McKinney Homeless Assistance Act of 1987 marks the first major piece of legislation that has addressed the homelessness issue. It is hoped that the many programs initiated under various departments will begin to provide some relief to those who suffer from one of the more serious social issues in the country. Preliminary attempts to reach the homeless elderly have found that many of them are depressed, have problems with interpersonal relationships, and have difficulty with transitional housing. Strategies to reach the homeless elderly must be developed to go beyond the provision of temporary shelter.

A greater Federal effort might be made to define adult illiteracy and collect the data to determine the actual size and scope of the problem. Additional funding could be used to encourage research into programs that work and provide seed money for promising techniques. The complexity of the issue—and its relation to national productivity, security, and welfare—suggests the need for a Federal concern beyond program funding or public awareness campaigns.

The Older Americans Volunteer Programs and VISTA will continue to receive broad bipartisan support because these programs have proven to be cost-effective, with measurable human benefits as well.

In view of increasingly limited Federal participation in transportation services, the role of State and local governments in the transportation area will become of major significance to needy elderly and handicapped persons. States will need to reassess priorities and focus attention on replacing Federal funding through increased State or local taxes or simply eliminating certain services. Although private sector contributions have played a significant role in social service delivery, it is unlikely that this revenue source will be adequate to close the gaps opened by Federal budget cuts in the area of specialized transportation services. Another resource—volunteer activities—has always been important in providing transportation services to older Americans. A report for the Administration on Aging on the transportation problems of older Americans indicated that many agencies servicing the elderly already extensively use volunteers in their programs. Given the limited resources which may be anticipated over the next decade, efforts to increase the role of volunteers are likely to become increasingly important.

It is a basic tenet in our society that those who live under the law should also have an opportunity to use the law. Access to the legal system for all persons is basic to our democratic system of government and the fundamental purpose of the Legal Services Corporation Act. The federally funded legal services program represents a significant improvement in the system of dispensing justice in this country and has gone a long way to alleviate the harsh consequences of being poor and unable to afford legal services. If we are to continue to make progress in the goal of equal justice and access for all, the continued funding of legal services by the Federal Government and the strengthened efforts of the private bar will be necessary.

Chapter 15

FEDERAL BUDGET

OVERVIEW

Following the enactment of a relatively modest fiscal year 1990 deficit reduction bill (the Omnibus Budget Reconciliation Act of 1989; P.L. 101–239), there was little optimism that the election year of 1990 would produce a bipartisan and significant deficit reduction measure. Beyond being an election year, there appeared little incentive for the President to compromise with the Congress on a budget.

Initially, it was felt by many that the so-called "peace dividend" would make it much easier to live with significant defense cuts, thus making it far more acceptable for the President than the Congress to live with an automatic across-the-board Gramm-Rudman-Hollings budget sequester. As a result, a possible sequester appeared to give the President a strong trump card should he not be satisfied with the budget brought to him by the Congress.

Skepticism about the possibility of a budget agreement was increased became the two major initiatives that would have the greatest impact on the budget and were receiving the most attention in early 1990 were believed by many to be revenue losers. Specifically, the President's capital gains proposal and Senator Moynihan's Social Security payroll tax reduction proposal were much more attractive to discuss than were painful deficit reduction proposals. As a result, many budget analysts concluded the Federal Government was headed away from any chance at real deficit reduction.

The budget equation changed, however, when new projections of the deficit and increasing fears of a recession made the prospect of a Gramm-Rudman budget sequester too painful for even the President and his administration to consider. On May 6, 1990, President Bush invited congressional leaders to the White House for an unusual Sunday session to explore the possibility of initiating high-level budget negotiations. Talks began on May 15, but did not go far until a statement made by the President in June appeared to open the door to an acceptance that new taxes would have to be a part of any significant deficit reduction effort.

Months of inter- and intra-party squabbling ensued. Finally, in early fall, an agreement between the President and the congressional leadership was achieved. However, the rank and file of both sides of the political fence were extraordinarily displeased with the package. Tax increases, including a significant gasoline tax, and major Medicare beneficiary cuts were the source of much dissatisfaction. As a result, as soon as the agreement was placed before the House of Representatives for a vote, it was soundly rejected.

After the congressional rejection of the budget summit package, the Congress quickly moved to develop a budget alternative. Finally, with the Gramm-Rudman budget sequester about to take place, the Congress and the President miraculously agreed to a 5-year, $490 billion deficit reduction measure barely a week before the 1990 election. The agreement was incorporated into the Omnibus Budget Reconciliation Act of 1990 and was signed into Public Law 101–508.

By the end of the year, the new law's increased taxes were starting to take effect. Although the public reaction was not overly negative, economists worried that the taxes could further slow down a recession-ridden economy. Further, the enforcement provisions included in the final agreement were coming under closer and negative scrutiny. Despite these concerns, it seemed highly unlikely that the hard won new budget agreement would be significantly altered in 1991.

A. BACKGROUND

1. The Budget Process

The Federal budget process is a prime example of the American Government's concept of shared powers. The provisions of Article 1 of the Constitution relating to the "power of the purse" give Congress primary control over financial affairs. However, while the budget is not explicitly mentioned in Article II detailing Executive powers, the President's general prerogative to see that the laws are faithfully executed makes the President a major partner in the budget process. From the outset, Congress has had to rely on the discretion of executive branch officials to implement the legislative provisions regarding public expenditures.

The Constitution does not contain specific provisions regarding a budget process. Informal procedures were developed and sufficed for many years until the Budget and Accounting Act of 1921 provided the framework for executive budgeting. This law requires the President to submit a consolidated budget proposal to the Congress each year. The President's budget, which has the status of recommendations, provides the starting point for congressional consideration of upcoming budgetary decisions.

In recent years, Congress has sometimes used the vehicle of a single omnibus continuing resolution to fund the entire Federal Government; this was the case in both fiscal years 1987 and 1988. However, for the 1989, 1990, and 1991 fiscal years, there was a return to more traditional budget procedures with 13 appropriations bills passed and enacted.

According to long-standing congressional procedures, the appropriations committees are supposed to conform to provisions in the "authorizing" legislation, emerging from the various congressional authorizing committees. In practice, particularly in recent Congresses, this procedure has not been closely followed. After the enactment of the regular appropriations for a given fiscal year, it is sometimes necessary to provide additional funding in a supplemental appropriations measure. Further, when appropriations laws are not enacted before the start of the fiscal year on October 1, short-term continuing resolutions often are used to provide temporary funding and allow Government operations to continue without interruption.

2. CONGRESSIONAL BUDGET RESOLUTION AND RECONCILIATION LEGISLATION

The budget process underwent substantial change as a result of the Congressional Budget and Impoundment Control Act of 1974. This law sought to restore to Congress some of the fiscal powers which had been surrendered over the years to the President by providing for a more coordinated and systematic congressional decisionmaking approach to the budget. The intent was to improve Congress' ability to view the budget as a whole and also to promote discipline among the authorizing committees.

The 1974 Budget Act established a congressional budget process centered around a concurrent resolution on the budget, scheduled for adoption prior to legislative consideration of revenue, spending, or debt-limit measures. (The law originally provided for adoption of two budget resolutions each year, but was amended in 1985 to provide for a single resolution to be adopted by April 15.) The budget resolution then sets the parameters for subsequent spending and revenue decisions which are made in separate tax bills, appropriations bills, and other measures.

A central component of the congressional budget process provided for in the 1974 law, and in use since 1980, is the reconciliation process. Reconciliation is a process provided for in the 1974 Budget Act whereby Congress makes any necessary changes in permanent statutes (spending and revenue laws) in order to bring them into conformity with the levels set in the budget resolution. To accomplish this, budget resolutions contain reconciliation instructions to congressional committees, directing them to recommend changes in existing law or pending legislation within their jurisdictions.

The submissions from the committees are assembled by the House and Senate Budget Committees into a single reconciliation measure. According to the timetable, the deadline for action by Congress on reconciliation is supposed to be June 15. In recent years, reconciliation bills have become the major focus for deficit reduction efforts and a principal instrument for implementing provisions of budget agreements between the President and Congress.

3. RECENT DEVELOPMENTS

The frequent use of special and comprehensive negotiations between representatives of the White House and Congress, outside the usual framework of the budget process, constitutes a recent development worth noting. While high level negotiations between Congress and the White House concerning the Federal budget certainly have taken place in the past, the decade of the 1980's saw the use of such a mechanism (known as a "budget summit") become the rule rather than the exception.

It is important to note the fact that these negotiations that take place do not by any means guarantee an agreement by the participating parties or the congressional acceptance and passage of an agreement. Since the participants in the sessions have no legal authority to commit their institutions (the administration and Congress), the resulting bipartisan agreements are not self-executing, a feature amply illustrated in the history of the 1990 budget summit. (For further discussion of the 1990 summit agreement and its provisions, see "Budget Legislation" section, below.)

In recent years, Congress has become increasingly frustrated with its budget process. Concerned about the potentially harmful economic effects of spiraling debt and spurred by constituent pressure to control the deficit, Congress has searched for measures to enforce discipline in the budget process and limit congressional discretion. Measures proposed have included a constitutional amendment to require Congress to report a balanced budget each year and legislation to provide the President with authority to veto individual line items in appropriations bills (the so-called line item veto). Although these two proposals have never been enacted, important changes in the budget process were enacted as part of the Gramm-Rudman-Hollings legislation in 1985 and 1987, and Title XIII of the Omnibus Budget Reconciliation Act of 1990 (see following section).

B. THE GRAMM-RUDMAN-HOLLINGS ACT

1. History

The need to raise the debt ceiling above $2 trillion in the fall of 1985 triggered a substantive legislative response in the Senate. In September, Senators Phil Gramm, Warren Rudman, and Ernest Hollings offered an amendment to the debt ceiling bill to reform the budget process by forcing the Congress to achieve specific deficit reductions targets each year to eliminate the deficit by 1991. Earlier versions of the bill received considerable bipartisan interest from both Houses as well as from the White House. Many Members feared the political and economic consequences of increasing deficit spending, yet were unwilling to set automatic reductions in motion. However, pressures to reduce the deficit were overwhelming and the Balanced Budget Act was signed into Public Law 99-177 in December 1985.

2. Deficit Reduction Targets and Sequestration

Gramm-Rudman-Hollings (GRH) provides for annual reductions in the budget deficit. To reach the original goal of a balanced budget by fiscal year 1991 (stretched out to fiscal year 1993 by the 1987 amendments), it specifies deficit targets for intervening years. In any year in which deficit targets are exceeded, the excess amount is to be automatically cut from the budget under a process known as sequestration. The act allows for a $10 billion margin-of-error over the deficit target for each year except the last, before sequestration occurs. The 1987 revisions also set maximum sequestable amounts for fiscal years 1988 and 1989 at $23 billion and $36 billion respectively.

The Gramm-Rudman sequestration process does not list specific cuts for particular programs, but calls for arbitrary, across-the-board reductions in all programs not specially protected. Only when Congress and the President do not pass a budget within the target limit will automatic spending cuts be set in motion. Prior to the passage of OBRA 1990, if the budget exceeded the target, the excess deficit was to be divided in half, one-half of the cuts being taken from the defense budget and the other half from domestic programs.

OBRA 1990 directs that the specific budget function responsible for the higher than permissible deficit be targeted for sequestration. The act sets up a procedure for calculating the resulting cuts. Cuts must come from unobligated funds. Obligated funds cannot be cut because this would put the Government in a position of breaching numerous contracts and commitments.

Gramm-Rudman-Hollings originally provided that a Presidential sequestration order be triggered automatically upon the issuance of a sequestration report (prepared by the Comptroller General of the General Accounting Office) which projected a deficit for a fiscal year in excess of the amount allowed under the act. This procedure was invalidated in 1986 by the Supreme Court, which, in *Bowsher* v. *Synar,* found the procedure to be unconstitutional because it violated the separation-of-powers principle by vesting executive power in a legislative branch officer. However, in anticipation of the possible invalidation of the automatic triggering procedure, Congress included fallback procedures in the act. These provided for the triggering of sequestration dependent upon the enactment into law of a joint resolution setting forth the contents of the joint Office of Management and Budget/Congressional Budget Office sequestration report.

3. Reductions in Programs Affecting the Elderly

Gramm-Rudman-Hollings controls the funding for Federal programs in two ways. First, the deficit targets encourage Congress to reduce spending by cutting or even restructuring programs. Second, if targets are not met and sequestration is called for, programs affecting senior citizens would be affected, at least partially, by the automatic cuts. Benefits paid under Social Security, Federal civil service and military retirement, Railroad Retirement Tier I and II, Medicaid, Food Stamps, SSI, and veterans' pensions are fully protected from sequestration. However, no such protection is given to the administrative costs of these programs, and there is a danger that the quality of service might deteriorate.

If deficit targets are not met, most health care programs including Medicare, veterans' health care, and community health centers are subject to cuts in excess of inflation, but generally not more than 2 percent. When a sequester occurred in fiscal year 1986, these programs were reduced by 1 percent. Although benefits were not directly reduced, payments to health care providers were cut, straining hospital resources. Further abrupt reductions in payment levels could result in reduced quality of care for Medicare and Medicaid beneficiaries.

Other domestic programs on which the elderly depend are vulnerable to unlimited across-the-board reductions based on a uniform percentage of current spending. When exempted and specially treated programs are removed from nondefense spending, approximately one-sixth of total outlays remain, and these programs are particularly vulnerable to severe reductions. In fiscal year 1986, for example, programs which provide important services such as housing, low-income energy assistance, Older Americans Act programs, social services, transportation, health research into Alzheimer's and other diseases, block grants, and home weatherization projects were cut by 4.3 percent.

4. LEGISLATION AFFECTING GRAMM-RUDMAN-HOLLINGS IN 1987

In 1987, after the 1986 Supreme Court ruling which invalidated the automatic trigger for sequestration, the Congress began debating a measure to raise the debt limit and restore the automatic trigger for sequestration. Adding fuel to the fire of debate was an OMB/CBO joint sequestration report that projected a fiscal year 1988 deficit of $153 billion—$45 billion above the statutory target. Sequestration implemented according to the terms of this report (without any modification of the deficit target) would have required that outlays be reduced by 12.9 percent for defense programs and 19 percent for nondefense programs. There was widespread agreement that cuts of this magnitude not only would be overly severe, but also could actually harm the economy.

After months of debate about how to fix the Gramm-Rudman-Hollings sequestration process and modify the deficit targets, Congress in September 1987 enacted changes in the 1985 Balanced Budget Act as part of H.J. Res. 324 extending the permanent statutory limit on the public debt. The two major purposes of these changes were to restore the automatic trigger for sequestration that had been invalidated by the Supreme Court and to modify the timetable for achieving a balanced budget in light of persistent high deficits. (See table 1.)

TABLE 1.—ORIGINAL AND 1987 DEFICIT TARGETS IN THE 1985 BALANCED BUDGET ACT AS AMENDED IN OBRA 1987

[Amounts in billions]

	Original target	1987 target
Fiscal year:		
1986	171.9	
1987	144	
1988	108	144
1989	72	136
1990	36	100
1991	0	64
1992		28
1993		0

5. LEGISLATION AFFECTING GRAMM-RUDMAN-HOLLINGS AND THE BUDGET PROCESS IN 101ST CONGRESS

As the 101st Congress began its work, considerable attention in Congress continued to focus on proposals to change the budget process, especially with regard to the Gramm-Rudman sequestration process. The continuing focus on a single number left Congress responsible for achieving a fixed deficit target even in the midst of economic and other changes which often increased spending beyond Congress' original expectations. This meant attempting to amend entitlement programs almost annually to effect savings. Such changes have been directed to the level of benefits, the pool of eligible recipients, the method of payment, or some combination of these and others factors.

Also of particular concern was the budgetary treatment of Social Security. Although Social Security trust funds have been treated as "off-budget" since the enactment of the original Gramm-Rudman-Hollings law in 1985, their totals continued to be reflected in calculations of the deficit for purposes of sequestration. Under this arrangement, the receipts and outlays of the Social Security trust funds were presented apart from the unified Federal budget in a special chapter of the Budget Appendix, but later summed with "on-budget" transactions to arrive at a measure of the deficit. However, the Social Security trust funds have moved into a period of large and growing reserves, accumulating in anticipation of an unprecedented surge of claims on the funds as the "baby boom" generation ages.

By including surpluses in calculations of the deficit, the size of the overall Federal deficit appeared to be less, easing compliance with the deficit targets mandated under Gramm-Rudman. This arrangement proved troubling to Chairman Pryor, Senator Heinz, Senator Moynihan and many other Members of Congress, who contended that by masking the true extent of the deficit in general revenues, this system also disguised the magnitude of the Nation's fiscal problems, delayed true deficit reduction, and could potentially weaken the future solvency of the Social Security system.

Several measures to address these concerns about the budgetary treatment of trust funds were introduced in Congress in 1989 and 1990 by Senators Heinz, Moynihan, Hollings, and other Members of Congress. In addition, hearings were held on this subject by the House Budget Committee, the House Government Operations Committee, the Senate Budget Committee, and the Senate Governmental Affairs Committee. Testimony on the budgetary treatment of trust funds was also heard during other hearings on the subject of budget process reform.

Added to this debate, Senator Moynihan made a well-publicized proposal in January 1990 to reduce the Social Security tax and return Social Security to a pay-as-you-go system. Floor consideration of this proposal was halted on October 10, 1990, when the Senate failed (54-44) to achieve the three-fifths majority necessary to waive the provisions of the Congressional Budget Act; such a waiver was necessary since reduction of the Social Security surplus would have had the effect of increasing the deficit. (A more detailed discussion of the Moynihan proposal can be found in Chapter 1.)

Substantial changes in the budget process grew out of the budget summit negotiations as well as these congressional efforts. These reforms were enacted as part of Title XIII of the Omnibus Budget Reconciliation Act (OBRA) of 1990, also known as the Budget En-

forcement Act, and included a major revision of Gramm-Rudman-Hollings.

These OBRA 1990 revisions included major changes to the sequestration process. These changes include modifying the deficit targets to take account of including the costs of the savings and loan bailout and removing Social Security from deficit calculations, and extending the sequestration process through FY 1995. (See Table 2.)

TABLE 2.—1987 AND REVISED DEFICIT TARGETS IN THE 1985 BALANCED BUDGET ACT AS AMENDED IN OBRA 1990

[Amounts in billions]

	1987 target	Revised target
Fiscal year:		
1988	144	
1989	136	
1990	100	
1991	64	327
1992	28	317
1993	0	236
1994		102
1995		83

While Subtitle C of OBRA 1990 reaffirmed the off-budget status of Social Security, it also removed it from calculations of the deficit for purposes of sequestration. This exclusion, along with the cost of the savings and loan bailout, was the major reason for the upward revision of the maximum deficit targets, and their extension to FY 1995.

When the trust funds surplus was included in deficit calculations it could offset the deficit and there was an obvious incentive for allowing the surplus to grow. Without this incentive, Members of Congress felt it necessary to establish rules to significantly inhibit its depletion. To achieve this goal, procedures were established as part of the Budget Enforcement Act (OBRA 1990) to protect the off-budget Social Security surplus.

For the House, a provision was enacted which creates a point of order to prohibit the consideration of legislation that would change the actuarial balance of the Social Security trust funds (that is, measures that would provide net increases in benefits or net decreases in revenues) over a 5-year or 75-year period. An exception provides for cases where a net decrease in Social Security revenues is accompanied by an equivalent increase in Medicare revenues.

For the Senate, a so-called "fire wall" is established by amending the existing provisions of the Congressional Budget Act. This expansion prohibits the Senate from considering a reported budget resolution which presumes a reduction in Social Security surpluses during the period covered by the resolution (that is, 5 years). It also prohibits the consideration of other legislation which would cause either committee allocations of amounts allowed by a budget resolution, or the aggregate level of Social Security spending, to be exceeded. As a result, 60 votes are needed in the Senate to waive the budget act and neutralize these prohibitions.

A number of other temporary and permanent changes to the budget act relating to Social Security were also included in OBRA 1990. Under this new law, both chambers will retain the current exemption of Social Security benefit payments from any sequestration order. In addition, the Board of Trustees of the Social Security trust funds is now required to include a statement in their report to Congress an accounting of the actuarial balances of the funds.

Perhaps the most significant changes to the sequestration process, however, are the addition of two new sequestration mechanisms, intended to enforce the deficit reduction agreement enacted in OBRA 1990. The first of these mechanisms establishes limitations on discretionary spending for defense, international and nondefense purposes, and provides that any amount in excess of the spending cap in any of these categories will subject all accounts in that category to an across-the-board cut. The second new mechanism is called a "pay-as-you-go" sequester, and would take effect if the net effect of new revenue and entitlement legislation would increase the deficit above the baseline. In this case, only nonexempt entitlement programs would be sequestered.

For sequestration orders issued under the new pay-as-you-go provisions, Medicare will be subject to a maximum reduction of 4 percent (for sequestration orders issued under the maximum deficit provisions the maximum reduction will remain 2 percent). The combined effect of these changes is to make sure that Congress is held accountable for all new spending initiatives, but that unexpected spending growth of some programs will not require that cuts be made elsewhere.

Other budget process changes of note in OBRA 1990 included an extension in the deadline for submission of the President's budget proposal to the first Monday in February. In addition, the President was given authority to revise the deficit targets to take account of economic and technical reestimates. And finally, the final sequestration order will be issued 15 days after the end of each session of Congress, rather than on October 15.

C. BUDGET LEGISLATION

1. President's Budget for Fiscal Year 1991

President Bush submitted his first full budget on January 29, 1990. The fiscal year 1991 budget was released as a single condensed volume, in place of the multiple documents of recent years. The proposed budget projected total spending of $1.23 trillion, and revenues of $1.17 trillion, leaving a deficit of $63 billion, just slightly under the $64 billion Gramm-Rudman-Hollings deficit target. However, critics charged that the economic assumptions were overly optimistic and the spending cuts unrealistic.

The budget submission did not reflect any major spending shifts or initiatives. As in recent years, it called for no cuts in Social Security while proposing a substantial $5.5 billion cut in Medicare from the amount necessary to maintain current service levels. Specific spending allocations for programs serving the elderly included $262.4 billion for Social Security, $107.8 billion for Medicare, $44.9 billion for Medicaid, and $13.2 billion for Supplemental Security

Income. Although the President avoided new taxes per se, the budget recommended various revenue enhancement measures, such as raising $600 million for HHS by charging drug companies for processing new product applications and by charging hospitals and nursing homes for inspections.

The President's budget also proposed several changes in the budget process, some of which had been submitted as a part of the Bush transition budget in FY 1990 and by President Reagan in earlier years. Recurring proposals included the call for a balanced budget constitutional amendment, a line item veto and an enhanced recision authority, a biennial Federal budget, and converting the congressional budget resolution to a joint resolution (subject to Presidential signature).

2. BUDGET SUMMIT AND 1990 BIPARTISAN BUDGET AGREEMENT

The framework for the congressional budget process provided in the 1974 Budget Act and the Gramm-Rudman-Hollings law was largely abandoned during the development of the budget for fiscal year 1991. On October 1, 1990, the beginning of FY 1991, Congress still had not agreed upon a budget resolution. The House approved H. Con. Res. 310 on May 1, 1990, and the Senate agreed to it, after substituting the text of its version (S. Con. Res. 129), on June 14, 1990. However, conference action was postponed pending the outcome of the budget summit.

In May, President Bush invited congressional leaders to the White house to discuss prospects for convening a budget summit. While President Bush stated that he had no "preconditions" for summit participation (implying an easing on the "no new taxes" campaign pledge), Democrats remained wary that the President would attempt to blame any necessary tax increases on their party. In general, most Republicans publicly stated they favored budget negotiations, but many were nervous that the President would turn his back on his no tax pledge. Despite the hope for a speedy agreement, it was therefore not too surprising that the summit talks got off to a slow start.

Relatively fruitless negotiations dragged on for over a month. Then on June 26, President Bush released an unexpected statement, suggesting that "tax revenue increases" needed to be a part of any deficit reduction plan. Democrats countered that they were now ready to consider significant cuts in entitlements, but the newly optimistic mood at the summit did not last. On July 16, OMB released the midsession review for the FY 1990 budget, with deficit projections revised upward, and OMB Director Richard Darman cautioned that a $100 billion sequester on October 1, 1990, appeared a real possibility unless Congress could agree on a deficit reduction plan. Despite the warning, the growing disagreement among the House Republicans could no longer be contained. Over the protests of the Bush administration and their own leaders, the rank and file Republicans in the House adopted a nonbinding resolution on July 18 opposing any new taxes to reduce the deficit. The following week, plans to exchange serious offers at the summit were shelved, as efforts in both Democrat and Republican caucuses failed to produce a draft agreement. Tempers among participants flared further as some details of tax proposals under discussion were leaked to the press. Democrats turned their attention to preparing for intense negotiations after the August recess, contending that the sides were too far apart realistically to achieve any deal before then. On September 7, the participants assembled in secluded quarters at Andrews Air Force Base (in suburban Maryland) to begin the final round of negotiations.

On September 30, at a Rose Garden gathering attended by President Bush and most of the congressional negotiators, and hours before the start of the new fiscal year, a bipartisan budget agreement was announced. The agreement consisted of a package of spending cuts and new taxes that would reduce the deficit by $500 billion over 5 years and by over $40 billion in fiscal 1991, and included a number of significant changes in the budget process. The biggest items in the unpopular package included cuts in defense spending, a 12-cent rise in gasoline tax, and substantial reductions in Medicare. There was little enthusiasm for the package, but the President and congressional leaders attempted to sell it as the best available way out of the budget stalemate.

Despite the support of the President and congressional leaders on both sides of the political fence, the House rejected the summit agreement in the early hours of October 5, by a vote of 179–154. The stunning defeat resulted from a rare alliance of conservative Republicans, who were vehemently opposed to the plan's new taxes, and liberal Democrats, who could not accept the Medicare cuts and the parts of the tax package they viewed as particularly regressive.

The unpopularity of the Medicare provisions in the September 30 agreement was generally acknowledged to be the most important single factor contributing to the defeat of the budget plan in the House. The original deal called for $60 billion savings over the 5 years in Medicare, almost half the package's total reductions in domestic spending. The agreement further assumed that half of the total savings would be achieved by requiring Medicare beneficiaries to pay higher premiums, deductibles, and coinsurance payments, with the remaining half to come from reducing payments to health care providers. This provision proved unpalatable to many Members.

3. Budget Resolution and Reconciliation

Summit participants stipulated that the September 30 deal had to be endorsed by a majority of both Republican and Democrat Members in order to be implemented, but that understanding was discarded after the October 5 defeat of the package in the House. In the aftermath of the rejection of the summit package, the Democratic majority in the House asserted its control and took the lead in drafting an alternative. However, the effort in the Senate to devise an acceptable budget deal continued to be more bipartisan; the 55 Democrats lacked the necessary majority to overcome a filibuster, and Republican support for the package was therefore essential.

After working throughout the weekend, the House approved a new budget resolution (H. Con. Res. 320—H. Rept. 101-820) on October 8, at about 2:30 in the morning, by vote of 250–164. Less than 24 hours later, the Senate followed suit, approving the resolution on October 9 by a vote of 66–33.

The new budget resolution was a stripped down model, with explicit tax and spending directives notably absent, but with the summit agreement goal of achieving $500 billion in deficit reduction over 5 years retained. While the original summit package had stipulated the source of savings, the new budget resolution provided only committee totals in reconciliation instructions. The largest share of the deficit reduction work fell to the House Ways and Means and Senate Finance Committees, but 11 other House Committees and 9 other Senate panels also were instructed to submit their plans by October 15.

Amid uncertainty over whether the White House would accept a revenue deal involving a cut in the capital gains tax along with an increase in the income tax rates for the wealthy, committees proceeded to craft their reconciliation packages. Initially, the House Ways and Means Committee approved a "bare bones" package, largely adhering to the budget summit agreement, but especially unpopular features, including altering smaller cuts in Medicare, increasing tax credits for the working poor (to compensate somewhat for the regressive tax increases), and elimination of the widely criticized small-business tax incentives. But 2 days later, on October 12, the Ways and Means Democrats approved an alternative reconciliation package providing more substantial shifts of tax increases to the wealthy while lessening the burden on others. The next day the Senate Finance Committee approved a bipartisan reconciliation package that generally followed the summit agreement, but with some modifications, including less severe cuts in Medicare and changes in tax provisions. The White House announced its support for the Senate version, but reacted negatively to the House package.

On October 16, the House voted to amend the reconciliation bill (H.R. 5835) as reported, by substituting the Ways and Means Democratic alternative for the "bare bones" package. In the early morning hours of October 19, the Senate passed H.R. 5835, by vote of 54–46, after inserting the text of S. 3209, the Senate reconciliation bill, as amended. Later that morning House and Senate conferees began their work. The particular challenge facing the conferees was to devise a compromise acceptable to most House Democrats without alienating Senate Republicans, since support from both groups was necessary.

After many days and nights of difficult negotiations, the sprawling Omnibus Budget Reconciliation Act of 1990 was reported from conference on October 26 (House Rept. 10-964, running 1,225 pages). Following an all-night session, the House voted 228–200 to approve H.R. 5835 near dawn on October 27. Less than 12 hours later the Senate passed the bill by vote of 54–45. President Bush signed the bill into law on November 5, 1990 (P.L. 101-508).

4. Final Fiscal Year 1991 Budget Agreement

The final budget agreement contained a 5-year, $492 billion deficit reduction plan (from baseline estimates), consisting of $147 billion in increased taxes and $345 billion in spending reductions (including interest payment savings). Savings in appropriations supplemented the reductions achieved in the reconciliation law. The Reconciliation Act also contained provisions making substantial changes in the budget process (Title XIII). (A detailed description of these changes is included in a previous section entitled "Legislation Affecting Gramm-Rudman-Hollings in 101st Congress.")

The so-called "peace dividend" contributed the largest source of savings in the final agreement: $182.4 billion in defense outlays in FY 1991–95 compared to the OMB defense baseline. However, the agreement deferred funding for the Persian Gulf operations to supplemental appropriations, so the total defense savings for fiscal year 1991 is uncertain.

The Reconciliation Act included significant tax increases from revisions in the income tax, higher gasoline taxes, higher excise taxes on alcoholic beverages and cigarettes, and a new excise tax on luxuries. Increasing the amount of income subject to the 1.45 percent Medicare tax from the 1990 level of $51,300 (indexed) to $125,000 is expected to raise $29 billion over 5 years. (The ultimately enacted conference agreement level surpassed the previously proposed caps of $73,000 in the September 30 budget summit agreement, $83,000 in the Senate version, and even of $100,000 in the House version.)

Medicare experienced the largest cuts of any single program in the Reconciliation Act, but the reductions were moderated from those originally proposed in the September 30 agreement. Instead of a $60 billion reduction, the final version called for 5-year savings of $42.5 billion. Also of note, the increase in payments faced by Medicare beneficiaries was reduced from $28 billion to $10 billion, with the bulk of Medicare cuts to come from reducing payments to hospitals, doctors, and other providers of medical services.

Other provisions in the Reconciliation Act of special concern to the elderly entailed expansions in Medicaid, including paying the Medicare premiums for poor Medicare beneficiaries and, beginning in 1993, near-poor beneficiaries, and providing benefits for home and community-based services for the frail elderly. These program expansions were made possible largely due to the enactment of legislation, introduced by Chairman David Pryor, to require that drug manufacturers give discounts to the Medicaid Program. This one provision is estimated to save over $1.8 billion in Federal spending over 5 years.

The Reconciliation Act also contained an estimated $7.6 billion savings over Fiscal Year 1991 through 1995 by suspending for 5 years the so-called "lump-sum" option for most Federal employees. As a result, during this period, Federal employees cannot continue to withdraw the amount of their retirement contribution at retirement and receive a smaller annuity.

5. APPROPRIATIONS MEASURES

In recent years, the reliance on omnibus budget legislation, epitomized by the passage in December 1987 of the 1,000-plus-page $605 billion appropriations measure for fiscal year 1988 and the even longer reconciliation law, has become a growing concern. President Reagan threatened a veto should still another omnibus appropriations measure follow the next year. But after several years of omnibus full-year continuing resolutions, in the fall of 1988 Congress completed action on all 13 regular appropriations bills before the start of the new fiscal year on October 1. This was the first time since 1976 (fiscal year 1977) that Congress had avoided the need for even a short-term continuing resolution to tide over funding of the Federal Government at the start of a new fiscal year.

In 1989, Congress succeeded in passing all 13 regular appropriations bills before adjourning on November 22d. However, three short-term continuing resolutions proved necessary—the first expiring October 25, the second November 15, and the third November 20. Only one FY 1991 bill was signed before November 1; eight bills were not signed until the closing hours of the sessions, after the expiration of the third continuing resolution. House-Senate disagreements delayed some measures, and then four bills (including two making appropriations for the District of Columbia) were vetoed by the President. Still, in avoiding an omnibus continuing resolution, 1989 could be characterized as the second year in a row that the "usual process" for appropriations bills prevailed.

In 1990, however, at the beginning of the new fiscal year on October 1, none of the 1991 appropriations measures had cleared Congress. Nevertheless, in a remarkable rush of activity during the course of the following month, Congress managed to pass all 13 regular appropriations laws before adjourning on October 27, scarcely a week before election day.

An omnibus continuing resolution was thereby avoided for the third consecutive year. However, five short-term continuing resolutions proved necessary, and the Federal Government had to shut down partially during a 3-day funding gap. The first continuing resolution for FY 1991, providing funds and suspending sequestration through October 5, was signed into law on October 1 (P.L. 101-403). The second continuing resolution, extending funding and postponing sequestration for 10 more days, was signed into law on October 9 (P.L. 101-412). Following the House defeat of the original summit agreement on October 5, President Bush refused to sign another spending extension until Congress adopted a budget resolution, so from October 6 to 8, spending authority lapsed. The third continuing resolution, providing a 5-day extension, was signed into law on October 19 (P.L. 101-444), and a fourth, for 3 days, was signed on October 25 (P.L. 101-461). The final continuing resolution, providing funds and suspending sequestration through November 5 (to allow time for engrossment of, and Presidential action on, reconciliation and the remaining regular appropriations bills), was signed on October 28 (P.L. 101-467).

D. PROGNOSIS

Following the extraordinarily difficult enactment of the 5-year, almost $50 billion 1990 budget agreement, it is difficult to imagine that the Congress or the President will have much of an appetite for another major budget summit. In contrast to last year, there is likely to be very little talk about a "peace dividend" in this year's budget process. In addition, the recession that was being acknowledged by even the administration as a reality in late 1990, as well as the criticism the President sustained after he broke his no new taxes 1988 campaign pledge, will certainly assure that the Congress and the President will be extremely hesitant about imposing additional taxes on a slumping economy.

Moreover, the new budget enforcement mechanisms included in the OBRA 1990 (that require direct offsets in either spending or new taxes) combined with the poor economy will make it virtually impossible to fund major new programs or expansions, let alone meet deficit reduction targets. This grim fiscal situation seems particularly likely when one considers the increasing costs associated with the multi-billion-dollar Persian Gulf military operation and the savings and loan crisis.

Having said this, neither the Congress nor the administration rarely ever is satisfied with the status quo. The two budget issues that received the greatest attention in the 101st Congress were left largely unresolved. Specifically, Senator Moynihan's proposal to cut regressive Social Security taxes in order to reduce the Federal Government's reliance on Social Security reserves to pay for the general operations of the government remains on the discussion table. Likewise, President Bush's desire to cut capital gains taxes remains a favorite for him and many in the Republican party. Whether these two issues will, once again, act to neutralize the other remains unclear, but it certainly is likely that they will receive attention in the 102nd Congress.

In late 1990 and early 1991, there was much less talk than usual about the President's fiscal year 1992 budget proposal and what it might contain. There appeared to be a continued debate within the highest levels of the President's advisors about how best to proceed on the budget, particularly on the domestic budget front.

Some within the White House and in the Congress were urging the President to become more active in domestic affairs and support a relatively new political and economic philosophy called the "new paradigm." Under this still to be fully developed philosophy, the government would prioritize continued reliance on market forces in hopes of being more competitive, empower the poor by allocating more resources in hopes of providing additional opportunities, and decentralize the government in hopes of making it more responsive. The Director of the Office of Management and Budget publicly criticized this philosophy and the people advocating it as "pretentious" and, as of this writing, it remains unclear whether the President will take a more active role in this area.

The most notable new budget idea that was being discussed inside the adminstration, as well as by the Senate Minority Leader, Robert Dole, was the concept of increasing the amount of the Medicare premiums that the well-to-do elderly have to pay and possibly use that revenue to reduce the Social Security payroll tax. Such a proposal would pay for some of Senator Moynihan's proposal to reduce the Social Security payroll tax. Following the extraordinarily negative reaction to and repeal of the catastrophic health care law in 1989, Congress has been extremely hesitant about raising out-of-pocket health care costs for older Americans, particularly in the absence of a desirable benefit expansion.

Since 1991 will probably not be a year of major budget reforms or new spending, the first session of the 102nd Congress will more likely be spent assuring that the 5-year budget agreement is implemented properly. To assure this, there can be expected to be a technical corrections bill introduced and passed by the end of 1991. Outside of technical changes, with the economy in recession and the oil market destabilized due to the Persian Gulf conflict, the Congress will likely spend some time attempting to reduce the impact of the recession on the public and finding ways to jump-start the economy. Along these lines, efforts to strengthen unemployment programs and encourage more business and consumer investment and spending are likely to be undertaken.

As stated previously, a bleak economic and budget picture makes unrealistic any significant reliance on new and major Federal spending increases to meet social policy needs. Once again, therefore, advocates of older Americans will primarily be relegated to protecting current levels of funding for programs, lobbying for incremental reforms in the public and private sector, and designing creative and modestly priced initiatives aimed at meeting the many needs of an ever-growing elderly population. Having said this, as the numerous legislative achievements outlined in the previous chapters of this report attest, creative and hard work combined with unexpected opportunities likely will continue to result in positive developments in aging in the 102nd Congress.

Supplement 1

First Older Americans Act Workshop: Reauthorization of the Act, Washington, D.C., January 31, 1990, Hon. David Pryor, Presiding

Presenters

James Solomon, Moderator, Senior Assistant Director, Program and Methodology Division, General Accounting Office

Dr. Percil Stanford, Professor, Center of Aging, University of California at San Diego

Dr. Robert Hudson, Professor, School of Social Work, Boston University

Dr. Robert Binstock, Henry R. Luce Professor of Aging, Health, and Society, Case Western Reserve University

Issues Raised and Presentation Summary

The Older Americans Act (OAA) was enacted in 1965 and has been reauthorized on 10 occasions, most recently in 1987. The Act serves to improve the lives of all older Americans in a variety of areas including income, health, nutrition, employment, and long-term care, among others. The Act establishes an Administration on Aging (AoA) within the Department of Health and Human Services, to administer the majority of the OAA programs and to act as the chief Federal agency advocate for the elderly. In turn, the AoA oversees a network of State and Area Agencies on Aging. The State and Area Agencies on Aging maintain responsibility for funding, coordinating, and managing a broad array of service programs and other initiatives for the elderly.

The OAA is scheduled for reauthorization in 1991. In order to identify key issues that may merit close examination as part of the reauthorization process, the Senate Special Committee on Aging sponsored a series of workshops in 1990. This workshop was the first of the series.

The first workshop focused general attention on the context of the OAA and addressed three broad areas: the populations who receive the services provided by OAA and the groups which were in greatest need; the mix of services offered under the Act; and the agencies at national, State, and local levels which are involved in the administration and implementation of the Act's objectives. The workshop also incorporated four themes throughout the discussion including advocacy, efficiency and effectiveness, gap filling, and equity.

Rising Medigap Premiums: Symptoms of a Failing System? Harrisburg, PA, January 8, 1990, Hon. John Heinz, Presiding

Witnesses

Janet Shikles, Director of Health Financing and Policy, GAO, accompanied by Tom Dowdal, Assistant Director for Medicine
Constance Foster, Pennsylvania Insurance Commissioner
Peter D. Archey, special assistant to the executive director, Pennsylvania Cost Containment Council
Harry Frantz, consumer specialist, Berks County Senior Citizen Council, Inc.
Helen Kushner, Freeland, PA
Thomas L. Coe, Sr., Pennsylvania State Legislative Committee, American Association of Retired Persons
Eugene J. Ott, executive vice president and chief operating officer, Independence Blue Cross
J. Patrick Rooney, chief executive officer, Golden Rule Insurance Co.
Robert J. Polilli, senior vice president and chief actuary, Colonial Penn Insurance Co.

Issues Raised and Testimony Summary

Senator Heinz held this hearing to examine the skyrocketing premiums for Medigap insurance coverage and in a broader context how these increases are a symptom of the continuing deterioration of protection under the Medicare program.

Although no definitive conclusion was reached which determined the cause of Medigap premium increases, most of the witnesses addressed the relationship of the repeal of the Medicare Catastrophic Coverage Act (MCCA) to the sharp rise in the cost of supplemental insurance coverage. In addition to the effects of the repeal of MCCA, other reasons cited for the increase in Medigap premium increases include: the medical inflation rate; the increased use of medical services which have become more complex and expensive; and the increasing average age of policyholders. Some witnesses also addressed the process by which premium increases are calculated and how these increases are reviewed by the Insurance Commission.

No recommendations for changes in the Medicare program were suggested as a result of this hearing, but Senator Heinz believes that some change in Medicare is needed in order to insure quality health care for every older American.

Medigap Policies: Filling Gaps or Emptying Pockets? Washington, D.C., March 7, 1990, Hon. David Pryor, Chairman, Presiding

Witnesses

Ed Kodish, incarcerated former insurance agent, St. Petersburg, FL (by videotape)
Charlene Blackburn, Santa Cruz, CA
Lois Hibbard, Riverside, CA
John Hildreth, Consumers Union Southwest Regional Office
Ronald O. Gaiser, Jr., private attorney from Alabama

Ron Taylor, Arkansas Insurance Commissioner
Bonnie Burns, Consultant to California State Health Insurance Counseling Program and to local HICAP programs
Jeff Spitzer-Resnick, Center for Public Representation
Thomas A. Sick, Vice President, Physicians Mutual Insurance Co.

Issues Raised and Testimony Summary

This hearing was held to discuss the problems surrounding Medicare supplemental insurance or Medigap. During the debate on the repeal of the Medicare Catastrophic Coverage Act, it became apparent that many older Americans are understandably confused about their health insurance needs and coverage, making them vulnerable to high pressure, and sometimes unscrupulous, sales practices.

Some of the marketing technqiues used by aggressive insurance agents were described by a former agent who testified by videotape from a Florida prison, as well as two witnesses who represented the many older Americans who have been taken advantage of by this kind of insurance agent. After high-lighting the problems faced by the consumer, testimony was given by representatives from different State counseling and assistance programs to show how these problems could be remedied.

In light of the success that some States have had with counseling programs, Senator Pryor, joined by more than half of the Aging Committee, announced the introduction of S. 2189, the Health Insurance Counseling and Assistance Act of 1990. This legislation was designed to give States the ability to establish programs to provide one-on-one health insurance counseling to older Ameriacns, thereby diminishing their vulnerability to the kinds of marketing and sales abuses which had been documented by testimony given at the hearing.

Aging in Place: Community-Based Care for Older Virginians, Charlottesville, VA, April 11, 1990, Hon. John Warner, Presiding

Witnesses

Helen Landford, Charlottesville, VA
W. Arthur Hasty, Charlottesville, VA
Olivette Hasty, Charlottesville, VA
Gordon Walker, Jefferson Area Board for Aging
John A. Owen, Jr., M.D., Charlottesville, VA
John Holly, Administrator, Martha Jefferson Hospital, Charlottesville, VA
Hon. Howard Cullum, Virginia Secretary of Health and Human Services
Thelma Bland, Virginia Commissioner on Aging
Bruce Kozlowski, Director, Virginia Department of Medical Assistance Services

Issues Raised and Testimony Summary

Senator Warner held this hearing to gain information about the issues of importance to Virginia senior citizens. Issues raised include long-term care, community services, and the roles of Federal, State and Local government that administer them. The Older Americans Act (OAA), which will go through the reauthorization process in 1991, was the main focus of the hearing.

The first panel of witnesses consisted of three older Virginians who depend on community services that help maintain normalcy in their lives and provide critical alternatives to institutional care. Health care professionals comprised the second panel and discussed the importance of maintaining independence for the elderly and advocated home health services as one way to achieve this goal. Virginia State Administrators, comprising the third panel, focused on the currently available services provided by Virginia State programs.

Respite Care in New Jersey, Lakewood, NJ, April 16, 1990, Hon. Bill Bradley, Presiding

Witnesses

Bill Anderson, Caregiver
Meredith Wagenblast, Caregiver
Margaret Bodrucki, Caregiver
Ann Ferrugiaro, Caregiver
Mary Fran McFadden, Administrative Supervisor of Social Work, Ocean County Board of Social Services
Mary Jane Kegelman, Program Director, Independence Place of Whiting
Barbara Vandenberge, Executive Assistant to the Director, Visiting Homemaker Service of Ocean County
Alan Gibbs, Commissioner of Human Services, State of New Jersey
Dudley Lesser, New Jersey State Coordinator for AARP/VOTE
Ruth Boer, Past President, Home Health Assembly of New Jersey

Issues Raised and Testimony Summary

Senator Bradley held this hearing in order to solicit testimony about the New Jersey Respite Care Pilot Project, a program that serves as a resource for those citizens who need assistance as family caregivers. This assembly provided an opportunity for the Senate to learn more about how the program is working for those who depend on its help and for those dedicated professionals charged with providing the services.

Four out of five Americans with physical or mental disabilities are cared for by family members at home. As a Nation, effective long-term care strategies must be built upon the family network. The Federal funding for the Respite Care Pilot Project was scheduled to expire in 1990. Senator Bradley stated two reasons why funding should be continued: the nearly 2,000 families helped each year in New Jersey need its services; it is a pilot program that deserves a full 4 years operation so that it can be adequately evaluated.

Testimony pointed out that the family caregivers have their own identities and needs. One example of the services provided by the New Jersey Respite Care Pilot was a program which offered a week of care for one 83-year-old daughter's 103-year-old mother, so that the caregiver could attend her granddaughter's wedding in another State. Services such as these are essential in relieving the stresses experienced by our family caregivers of this Nation.

Second Older Americans Act Workshop: Information Systems for Consumers and the Aging Network, Washington, D.C., April 19, 1990, Hon. David Pryor, Presiding

Presenters

James Solomon, Moderator, Senior Assistant Director, Program and Methodology Division, General Accounting Office

Mohamed Al-Ibrahim, M.D., Associate Professor and Head of Division of General Internal Medicine, University of Maryland School of Medicine, Baltimore, MD

Sue Boyd, Vice President of Community Services, Mile High United Way, Denver, CO

Robert Logan, Executive Director, Council of Aging in Cincinnati, Inc.

Richard Sugiyama, Director of Case Management, Seattle-King County Division on Aging, Seattle, WA

William Bechill, Associate Professor, School of Social Work and Community Planning, University of Maryland, Baltimore, MD

Rosalie S. Abrams, Director, Maryland State Office on Aging, Baltimore, MD

Cheryll Schramm, Director, Atlanta Regional Commission, Atlanta, GA

James Loftis, Executive Director of Services and Opportunities for Seniors, Inc., North Little Rock, AR

Issues Raised and Presentation Summary

The forum focused on the importance of information and referral services which are central to the purpose of the Older Americans Act (OAA). Secondly, the session sparked ideas for improving communications and dissemination of information within the Aging network. In this area, two critical issues include the types of information and data that should be collected and how that information should be shared with other interested parties.

One recommendation proposed by the University of Maryland Medical School in Baltimore for the reauthorization of the OAA was to support and fund demonstration projects. These would improve information transfer via a database that would contain medical, sociological, and functional client information. This database would link providers with available community resources for our elderly citizens. The proposed information system could facilitate resource and patient tracking, reduce duplication of services, and minimize the fragmentation of care. Another recommendation proposed that the Administration on Aging be required to strengthen its role in technical assistance. This provision would be a key to assuring effective information flow.

New Directions for SSA: Revitalizing Service to the Public, Washington, DC, May 18, 1990, Hon. David Pryor, Chairman, Presiding

Witnesses

Joseph F. Delfico, Director, Human Resources Division, GAO
Gwendolyn S. King, Commissioner, Social Security Administration
Sandra Boles, Fairborn, OH
Myrtle Osburn, North Little Rock, AR
Paul Welch, Susquehanna Legal Services
Mary O'Malley, claim representative, American Federation of Government Employees
Jack Delaney, former Operations Supervisor, SSA
John J. Pagoda, Claims Representative, SSA

Issues Raised and Testimony Summary

The purpose of this hearing was to focus attention on some of the issues facing the Social Security Administration and to encourage Commissioner King to revitalize some of its services. The implementation of SSA's 800 number and its dehumanizing effect was of particular interest to Committee members.

Although testimony from Commissioner King defended the use of computers and telecommunications technology as being both efficient, responsive, and necessary, other witnesses, including a GAO representative, presented testimony which challenged the accuracy of SSA's figures. Related testimony focused on how SSA staff cutbacks and subsequent overworked service representatives had resulted in beneficiaries being removed from disability rolls or being denied access to information regarding Supplemental Security Income (SSI). Once again, reliance on the 1-800 number and computers was seen as the reason for depersonalizing the SSA system and deterioration of service.

Eleven members of the Aging Committee have cosponsored legislation which would restore access to the local SSA office. This proposed bill is seen as one way to revitalize SSA service to the public.

Rural Health Care for the Elderly, Sioux Falls, S.D., May 29, 1990, Hon. Larry Pressler, Presiding

Witnesses

Congressman Tim Johnson
Jim Ellenbecker, Secretary of the Department of Social Services
Dr. Robert Schmidt, Chiropractor, Tieszen Clinic
Kathy Nickelson, LPN, Human Services Center
Lil Norlin Kleinsasser, Alzheimer's Association
Morris Magnuson
Bonnie Brown, Vice President of Operations, Evangelical Lutheran Good Samaritan Society

Issues Raised and Testimony Summary

This hearing was held for the purpose of examining three issues confronting the rural elderly: the cost of nursing home care; the skyrocketing cost of supplemental (Medigap) premiums; and expanding Medicare coverage to include additional health benefits.

Many of the witnesses testified about the need to address the issue of long-term care, both in traditional nursing homes and alternative long-term care services. Congressman Johnson mentioned legislation that he sponsored which specifically relates to the purposes of the hearing. A State government official asserted that the Federal Government should expand Medicare coverage to include nursing home care because States alone cannot afford this responsibility. Other witnesses suggested the expansion of Medicare coverage to include chiropractic care, home health care, and other basic health benefits which would help older Americans enjoy both a healthier and independent lifestyle.

Retirement and Health Planning, St. Petersburg, FL, May 30, 1990, Hon. Bob Graham, Presiding

Witnesses

Dr. Hal C. Riker, Professor Emeritus, University of Florida
Dr. William Hale, Medical Director, Florida Geriatric Research Program
Norman Bungard, Assistant District Manager, SSA
Dr. Larry J. Polivka, Assistant Secretary, Aging & Adult Services, Florida Department of Health and Rehabilitative Services
Maureen Sherman-Kelly, Executive Director, West Central Florida Area Agency on Aging
Tessa Macaulay, Director of Gerontological Programs, Florida Power & Light Co.
Diana Morgan, Vice President for Government Relations, Walt Disney World Co.
J. Pomeroy Carter, President, Advent Christian Village, Inc.
Walter Hill, Volunteer Retirement Counselor, AARP
Esther Piper, Retiree

Issues Raised and Testimony Summary

This field hearing was held for the purpose of exploring the ways pre-retirement planning can be used to assist an increasingly aging population make a smooth transition into their retirement years. Studies indicate that the middle aged, pre-retirement population is concerned about health and wellness, finances, safety, transportation, and lifestyle changes, but unfortunately wait too late to change major lifestyle decisions.

Testimony showed that pre-retirement planning occurs in a number of settings, including the workplace, State-provided retirement guides, and various organizations. A witness from Florida Power & Light told about the extensive retirement planning and preparation program for their employees. Seminars, workshops, and lectures were available to give expert advice on estate and financial planning, legal matters, health, Medicare and Social Security, etc. FPL believes there is value in funding these kinds of activities because the benefits of a healthier lifestyle and enhanced financial condition of the retiree outweigh the expenses incurred by the company.

Organizations such as AARP and Area Agencies on Aging offer retirement planning programs, and it was suggested that the Federal Government could play a role by publicizing the need for this kind of planning.

Hospice and Respite Care, June 18, 1990, Elizabeth, NJ, Hon. Bill Bradley, Presiding

Witnesses

Phil Pearlman, Director, Union County Division of Aging
Thelma May Smith, caregiver
Owen Morrison, caregiver
Joe Moore, caregiver
Dorothy Jensen, caregiver
Raphael Grimes, caregiver
Thelma Perkins, caregiver
Bernadette Dwyer, caregiver
Margaret Coloney, President, Center for Hope Hospice
Sarah Miller, Jewish Family Service
Victoria Hasser, Director, WISE Social Day Care Center
Diane Jones, Vice President and Legislative Co-Chairman, New Jersey Hospice Organization
David Keiserman, Co-Legislative Chairman, New Jersey Chapter of the Council of Senior Citizens
Pat Freeman, Older Woman's League

Issues Raised and Testimony Summary

Senator Bradley held this hearing in New Jersey to assess the benefits and needs of the Respite Care Pilot Project, a program funded by the Federal Government. This project is important because it shows a humane approach to long-term care: respite care, home health benefits, and adult day care. The value of hospice care was also addressed at the hearing.

Several witnesses gave testimony about the beneficial effect of respite care to the caregiver. Relief time to take care of personal business, go to work, or just to "take a break" from the constant dailiness of caring for a loved one at home were cited as the kinds of lifesaving benefits received from the Respite Care project. Witnesses also testified about the benefit of the supportive services of hospice care, enabling families and patients to deal with the inevitability of death.

It was suggested by the last panel of witnesses that these kinds of programs be continued and expanded because they are not only cost-effective but also improve the quality of life for the elderly.

Third Older Americans Act Workshop: Barriers to Effective Advocacy: Ombudsman and Legal Services Experiences, Washington, D.C., June 28, 1990, Hon. David Pryor, Presiding

Presenters

Carol O'Shaughnessy, Moderator, Congressional Research Service
James Kautz, State Long-Term Care Ombudsman, Governor's Office of Elderly Affairs, Baton Rouge, LA

Anne Kisor, Long-Term Ombudsman Department, Philadelphia, PA
Susan McDonough, State Long-Term Care Ombudsman, Office of Elderly Affairs, Boston, MA
Roland Hornbostel, State Long-Term Care Ombudsman, Ohio Department of Aging
Elias Cohen, Community Services Institute, Narbeth, PA
Ann Fisher, Legal Assistance Foundation of Chicago, IL
David Manley, Legal Services of Arkansas
Arnold Whedbee, Evergreen Legal Services, Seattle, WA
Penelope A. Hommel, Executive Director of the Center for Social Gerontology, Inc., Ann Arbor, MI

Issues Raised and Presentation Summary

The third in a series of Older Americans Act workshops examined barriers to effective advocacy on behalf of vulnerable senior citizens. This session focused on two services authorized under the OAA which have a unique client advocacy mandate—long-term care ombudsman and legal assistance.

In the 1978 amendments to the Act, Congress required each State to establish a long-term care ombudsman program which in time has expanded dramatically across the country, providing vital advocacy services to vulnerable residents of nursing homes and board and care facilities. According to information gathered from the first panel, in 84 percent of the States, a resident cannot expect to have an ombudsman in his/her facility more than once a month, and most residents in many States have never seen an ombudsman. Consideration for legislative or regulatory reform was suggested in two areas: (1) the funding of ombudsman services independently of other services funded under Title III–B of the Act; and (2) the allocation of ombudsman program funds to the States based upon factors that directly relate to the responsibility of the various State programs.

Witnesses testified that older Americans require legal aid in many areas including Social Security, Medicare, and landlord-tenant matters, among others. However, those providing OAA services face substantial barriers in providing effective legal advocacy, especially due to the lack of funds. A number of options were discussed to address the shortcomings of the Act in this area, and the first recommendation called for increased allocation of funds for legal services.

Disabled Yet Denied: Bureaucratic Injustice, Washington, D.C., July 17, 1990, Hon. David Pryor, Chairman, Presiding

Witnesses

Rita Hartley, Fort Smith, AR
June Herrin, New Orleans, LA
Joseph F. Delfico, GAO, Director, Human Resource Division
Lou Enoff, SSA, Deputy Commissioner for Programs
Stan Kress, Director, Idaho Disability Determinations Unit
Howard Thorkelson, Director, PA Bureau of Disability Determination
Harry P. Behret, SSA Claims Representative

Issues Raised and Testimony Summary

This hearing was held for the purpose of focusing attention on the administration of the two largest disability programs in the country: Social Security Disability Insurance and Supplemental Security Income. An investigation by the Aging Committee uncovered some longstanding flaws in the system that have grown worse in recent years. Too often people have gone through the confusing disability application process only to be denied benefits. While the Social Security Administration probably handles most of its workload fairly and efficiently, errors and delays can have tragic consequences.

Testimony given by two witnesses described becoming homeless and going without food and needed medical care after being denied disability benefits and waiting for the Government to undo its mistakes. In attempting to assess the cause of the errors made by SSA, testimony from a GAO representative suggested that the accuracy of the Social Security disability criteria and determination process was questionable. Other reasons related to the budgetary constraints on the State disability determination services by the SSA during the last few years.

Some of the solutions to the problems encountered by those who are disabled but who have been denied benefits include: early-stage face-to-face interviews which will result in better decisions in the initial phase of the determination process; eliminating a step in the appeals process; and also resolving budget challenges that threaten the system.

Defining the Frontier: A Policy Challenge, Casper, WY, July 23, 1990, Hon. Alan Simpson, Presiding

Witnesses

Mary Netzner, Home Health Care Consultant, Wyoming Department of Health and Social Services

Ken Heinlein, Interim Administrator, Wyoming Department of Health and Social Services

Carol Miller, MPH, Chair, Rural Health Committee, American Public Health Association

Larry Meuli, M.D., Administrator, Health and Medical Services, State of Wyoming

Evonne Ulmer, Administrator, Weston County Hospital, Newcastle, WY, Chairman, Wyoming Hospital Association

David Driggers, M.D., Director, Netrona County Family Practice, Program Director, University of Wyoming Family Practice Residency Program

Steve Zimmerman, Administrator, Division of Community Programs, Wyoming Health and Human Services Department

E. Scott Sessions, Director, Wyoming Commission on Aging

Issues Raised and Testimony Summary

This hearing was held in order to define the word "frontier" and differentiate the term from "rural" or "urban." Senator Simpson stated that Wyoming has counties where the principal community comprises 70 percent or 80 percent of the county's population base. This equates to a dispersion which is much less than six persons per square mile.

The hearing examined some of the special needs and unique circumstances that characterize frontier areas. Both State program administrators and providers testified as witnesses before the Committee. Their daily work includes matching means to ends under program regulations. Frontier America is very complex and extremely diverse. The population of frontier America is growing older and the need for more and higher levels of health service is increasing. Because health care and supportive services are in such high demand, the challenge is to craft a public policy response that is appropriate for all regions.

Long-Term Care for the Nineties: A Spotlight on Rural America, Little Rock, AR, August 21, 1990, Hon. David Pryor, Presiding

Witnesses

Joycelyn Elders, M.D., Director, Arkansas Department of Health
Pearl Herman, Advocate, Arkansas Department of Human Services
Steven Collier, M.D., Medical Director, White River Rural Health Center
Jim Loftis, Director, Services & Opportunities for Seniors
Charles McGrew, Director, Division of Health Facilities, Arkansas Department of Health
Edward Haas, Contract Services Supervisor, White River Area Agency on Aging
Dr. Catherine Donald, Capital Pharmacy
Ms. Cynthia Brandon, Private Attorney
Dr. David Lipschitz, Director, Geriatric Research Education and Clinical Center, John McClellan Memorial Veteran's Hospital

Issues Raised and Testimony Summary

Senator Pryor convened this hearing to address issues of comprehensive long-term care in rural areas, defined as all of the services required by a person who is functionally disabled. These services include medical and nonmedical long-term care, transportation, preventive care measures, and nutrition.

The hearing began with a video entitled, "Growing Old in Rural America: Is Dignity the Price?" This film, produced by the Staff of the Senate Special Committee on Aging, focused on frail elderly citizens in rural towns of Arkansas who face problems on a day-to-day basis. These challenges include minimal access to health care and the lack of transportation services.

According to national polls, 80 percent of Americans have or will need, within the next 5 years, long-term care for either themselves or a family member. The long-term care problem was broken down into three major issues: (1) limited availability of many services for rural areas; (2) affordability of these services for the poor; and (3) continued funding shortages for long-term care needs.

Another area of interest discussed at length was the skyrocketing price of prescription drugs. Drug costs represent the highest out-of-pocket expense for three out of four older Americans. Furthermore, over 15 percent of the elderly report they cannot afford the medications they need. In response to this situation, Senator Pryor informed the hearing participants that he introduced legislation earlier in the year to assure access to needed medications, providing the Medicaid program the savings it deserves.

Crimes Against the Elderly: Let's Fight Back, Reno and Las Vegas, NV, August 21 & 22, 1990, Hon. Harry Reid, Presiding

Witnesses

Romaine Frommer, Reno, NV
Tina Neuneker, Social Worker, Department of Human Services, State of Nevada
Arnold H. Greenhouse, M.D., Director of Geriatrics and Gerontology, University of Nevada at Reno
Max Goodman, Reno, NV
Jack E. Swagerty, Regional Chief Postal Inspector
Gail Bishop, AARP
Mike Errea, Reno, NV
Don Cavallo, Washoe County Public Administrator, Public Guardian
Charles Shepherd, Supervisory Special Agent, Federal Bureau of Investigation
Gertude Wynn, Las Vegas, NV
Jo Ann Angerson, Social Worker, Abuse and Neglect Investigator
Rose Di Mino, Las Vegas, NV
Karen Corcoran, Las Vegas, NV
Jared Shafer, Clark County Public Administrator, Public Guardian

Issues Raised and Testimony Summary

Senator Reid called this field hearing to address various types of vicious crimes inflicted upon the elderly population. The Senior population in Nevada has doubled in the last decade. Furthermore, the incidence of elder abuse across the Nation is up 50 percent—from 1 million victims in 1980 to 1.5 million victims in 1990. States only spend $3.80 for each elderly resident per year for protective services, in spite of the fact that 40 percent of family abuse involves elderly victims.

Social Workers and experts in the fields of crime prevention and geriatrics testified about the problem of mail fraud, physical abuse and financial exploitation directed against the senior citizens of our Nation. Nevada citizens who were victims of such crimes testified as well. According to witness testimony, the elderly are susceptible to many abusive practices. Reasons for this susceptibility range from social values and attitudes toward the elderly to their physical frailties and economic needs.

It is imperative that the senior population be aware of the types of criminals that may take advantage of them and to learn ways to protect themselves. The outcome of this hearing was to raise public awareness of fraudulent acts committed against the elderly in an attempt to prevent these crimes before they happen.

Improving Access to Primary Health Care, Albuquerque, NM, August 28, 1990, Hon. Pete Domenici, Presiding

Witnesses

Dr. Joyce Berry, Commissioner, U.S. Administration on Aging
Jeff Sanders, Director, Office of Legislation and Policy, Health Care Financing Administration
Alex Valdez, Secretary, New Mexico Human Services Department
Stephanie J. Fallcreek, D.S.W., Director, New Mexico State Agency on Aging
Peggy Folk, Executive Director, New Mexico Primary Care Association
Karen Wells, Executive Director, New Mexico Association for Home Care
Winnifred Connor, New Mexico Seniors Coalition
Lucy Montoya, Portales, NM
Mary Aguilar, Portales, NM
Jim Riebsomer, Presbyterian Medical Services
Olivia Reid, Roswell, NM
Margaret Burton, Albuquerque, NM

Issues Raised and Testimony Summary

Senator Domenici called this hearing to examine the importance of primary health care and the particular problems older Americans face in getting access to needed primary care services. Health care costs are now the fastest growing, major portion of the Federal budget; yet, nearly 32 million Americans lack health coverages. Many people do not receive the primary health care services that they should. This is due to the fact that they cannot afford them or because they are denied access simply because health care services are not available in their area.

The hearing focused on those individuals who are trying to meet the health and other service needs of seniors through Community health centers and senior centers throughout the State. These clinics play a crucial role in providing access to those in medically underserved areas. According to witnesses, assuring access for the delivery of food, health care, and social needs all depend on transportation. Unfortunately, in 1984, 75 percent of rural elderly in New Mexico lacked adequate means of transportation. Thus, transportation access is an additional problem included in the lack of adequate health care.

America's health care system is in tremendous need of reform. Methods to improve this situation, such as legislative proposals to expand coverage and curb cost growth, were discussed.

Joint Special Committee on Aging and the Congressional Black Caucus Health Braintrust, Profiles in Aging America: Meeting the Health Care Needs of the Nation's Black Elderly, Washington, D.C., September 28, 1990, Hon. David Pryor, Chairman and Hon. Louis Stokes, Chairman, Presiding

Witnesses

Carol Crecy, Acting Deputy Associate Commissioner for State and Community Programs, U.S. Administration on Aging
Dr. Charles Johnson, President, National Medical Association
Hazel Harper, President, Robert T. Freeman Dental Society
C. Alicia Georges, President, National Black Nurses Association
Wendell T. Hill, Jr., President, National Pharmaceutical Assn.
Shirley Bagley, Assistant Director for Special Programs, Nat'l. Institute on Aging
Gorham L. Black, Jr., Co-chairman, National Caucus and Center on Black Aged, Inc.
Dr. George W. Davis, Executive Director, National Black Aging Network
John A Eason, Administrator, Lee County Cooperative Clinic, AR
Brian Abdul-Karim Activities Outreach Director, Greater Washington Chapter, Alzheimer's Association

Issues Raised and Testimony Summary

This joint hearing was the first in a series of hearings designed to focus attention on the specific health care needs of minority groups. In examining the health status of the black elderly, statistical information is available which raises particular concerns: shorter life expectancy of black Americans; higher incidence of death from strokes in the black community; highest cancer mortality rates of any population group in the Nation; and the lack of adequate health insurance and care due to the disproportionate number of black Americans in a lower economic status.

Expert testimony from health care professionals cited some of the reasons for the special needs of the black elderly, focusing particularly on the lower income status which affected everything from diet to health care access. Most of the witnesses made recommendations for addressing these problems, including setting new priorities for spending Federal funds and the development of community-based health care programs. Other suggestions called for more researchers and health care personnel sensitive to cultural and ethnic characteristics, and encouraging historically black colleges to sponsor gerontology programs.

Fourth Older Americans Act Workshop: Meeting the Challenges of a Graying America, Washington, D.C., October 18, 1990, Hon. David Pryor, Presiding

Presenters

James C. Musselwhite, Moderator, Senior Social Science Analyst, U.S. General Accounting Office
Carol Crecy, Acting Deputy Associate Commissioner for State and Community Programs, Administration on Aging

Herb Sanderson, Director, Division of Aging and Adult Services, Little Rock, AR
Edward Keenan, Director, Montgomery County Aging and Adult Services, Norristown, PA
O. Lewis Harris, Director, Forest Hills Community House, Forest Hills, NY
Sidney Murphy, Director, Preston County Senior Citizens, Inc., Kingwood, WV

ISSUES RAISED AND PRESENTATION SUMMARY

The workshop focused on ways to improve the dissemination of information within the Aging Network, provide the State Units on Aging and Area Agencies on Aging the technical assistance they need, and support those who are actually engaged in the provision of services to older Americans.

The Administration on Aging undertook an initiative to improve the dissemination of information by tabulating the 1990 census sample data. The primary purpose of this project is to develop statistical information useful to State and Area Agencies on Aging in planning and evaluating aging programs. Another example of improvement methods was the recently established Private Sector Management Committee. This body will increase awareness of the challenges of the changing demographics and stimulate the expansion of services and resources for older persons by promoting and expanding public/private partnerships.

Another recommendation from witnesses includes the hope for public policy in the future that supports the individual's right to receive care, especially the right to expect that care will be so coordinated and organized as to assure that it is appropriate.

Seminar on Resident Assessment: Springboard to Quality Care and Quality of Life for Nursing Home Residents, Washington, D.C., October 22, 1990, Hosted by Senate Special Committee on Aging and Subcommittee on Aging of the Senate Committee on Labor and Human Resources with the Campaign for Quality Care and the National Citizen's Coalition for Nusing Home Reform

Participants

Susan Rourke, NCCNHR Board President
Catherine Hawes, Senior Policy Analyst, Center for Population and Policy Studies, Research Triangle Institute, NC
Katharine Murphy, R.N., MSN, Hebrew Rehabilitation Center for the Aged, Boston
Sarah Greene Burger, R.N., NCCNHR Consultant, Washington
Maggie Donius, R.N., MSN, Benedictine Nursing Center, Mt. Angel, Oregon
Steven Levenson, M.D., Medical Director, Levindale Geriatric Center, Baltimore, MD
Sara Hunt, A.C.S.W., Consultant in Aging Services, Midland, MI
Ruth Perschbacher, RMT-BC, ACC, National Association of Activity Professionals, Bristlecone Consultant Co., Asheville, NC
Tom Snader, Ph.D., Pharmacist, Sellersville, PA

Ann Gallagher, RD, LD, Dietitian, Fort Wayne, IN
Robert Joyce, Physical Therapist, College Park, MD
Caryl Gormly Gurski, OTR, Occupational Therapist, Hillhaven Corp., West Allis, WI
Julie Ouellette, Certified Nursing Assistant, South Yarmouth, MA
Lydia Borkin, Coalition of Institutionalized Aged and Disabled, NY, NCCNHR Board Member
Kathleen Gannoe, Bluegrass Long Term Care Ombudsman, Lexington, KY, NCCNHR Board Secretary
Scott Severns, Attorney, United Senior Action, Indianapolis, NCCNHR Board Vice President
Jamie Pipher, Sowerby Administrative Services, Petersboro, NH
Joyce Steier, R.N., Administrator, Oak Manor Nursing Home, Largo, FL
Jenean Erickson, R.N., Administrator, Yorkshire Manor, Minneapolis, MN
Mary Lucero, President, Geriatric Resources, Orlando, FL
John Hogan, Administrator, Benedictine Nursing Center, Mt. Angel, Oregon
Charles Phillips, Research Policy Analyst, Research Triangle Institute, NC
William Scanlon, Ph.D., Co-Director, Health Policy Center, Georgetown, Washington, D.C.
Carol Benner, Director, Office of License and Certification Programs, Dept. of Health and Mental Hygiene, Baltimore, MD
Hollis Turnham, State Ombudsman, Citizens of Better Care, MI
Patrick Flood, Director, Division of Licensing and Protection Dept. of Health, Williston, VT
Fran Sutcliffe, Nursing Home Hotline Patrol, St. Petersburg, FL
Elma Holder, Executive Director, NCCNHR, Washington, D.C.

Issues Raised and Seminar Summary

This seminar was developed through the combined efforts of the Senate Special Committee on Aging, the Subcommittee on Aging of the Senate Committee on Labor and Human Resources, the Campaign for Quality Care, and the National Citizens' Coalition for Nursing Home Reform. Health care professionals from all over the country were brought together to talk about their experience with resident assessment and other aspects of OBRA 1987 nursing home reform.

Resident assessment, as described by OBRA 1987, should be comprehensive, accurate, standardized, and reproducible; if the assessment instrument is implemented the way it has been proposed to HCFA, then it will truly become the springboard for good care and quality of life for the residents. The first panel of participants discussed what the resident care needs are, what the resident's desires are, and how she or he would want life to be in a nursing home. The second panel looked at how the care in a facility can be organized in order to meet those needs and desires, the hopes, the dreams, and the glimpses of the future. The third part of the program talked about the effective implementation and enforcement of OBRA from the perspective of consumers, residents, and professionals.

Supplement 2

COMMITTEE PRINTS ISSUED BY THE SPECIAL COMMITTEE ON AGING IN 1990

Skyrocketing Prescription Drug Prices: Turning a Bad Deal Into a Fair Deal, January 1990, Serial No. 101-F.

Protecting Older Americans Against Overpayment of Income Taxes, January 1990, Serial No. 101-G.

Untie the Elderly: Quality Care Without Restraints, February 1990, Serial No. 101-H.

Reauthorization of the Older Americans Act, February 1990, Serial No. 101-I.*

Aging America: Trends and Projections (Annotated), February 1990, Serial No. 101-J.

President Bush's Proposed Fiscal Year 1991 Budget for Aging Programs, March 1990, Serial No. 101-K.

A Guide To Purchasing Medigap and Long-term Care Insurance, Serial No. 101-L.

Older Americans Act Workshop No. 2, April 19, 1990, Serial No. 101-M.*

Older Americans Act Workshop No. 3, June 28, 1990, Serial No. 101-N.*

Understanding Medicare: A Guide for Children of Aging Parents, July 1990, Serial No. 101-O.

New Research on Aging: Changing Long-Term Care Needs by the 21th Century, July 19, 1990, Serial No. 101-P.

A Guide To Purchasing Medigap and Long-Term Care Insurance (Annotated), August 1990, Serial No. 101-Q.

Older Americans Act Workshop No. 4, October 18, 1990, Serial No. 101-R.*

Nursing Home Reform: Something Good is Happening, October 22, 1990, Serial No. 101-S.*

Understanding Medicare: A Guide for Children of Aging Parents, January 1991, Serial No. 101-T.

Disabled Yet Denied: Bureaucratic Injustice in the Disability Determination System, December 1990, Serial No. 101-U.

Supplement 3

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Christopher C. Jennings, deputy staff director
Christine V. Drayton, chief clerk

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Kendra Dimond, investigative counsel
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Supplement 4

PUBLICATIONS LIST

HOW TO ORDER COPIES OF COMMITTEE HEARINGS, REPORTS, AND COMMITTEE PRINTS

The Special Committee on Aging, under the direction of its Chairman, publishes committee prints, reports, and transcriptions of its hearings each year. These documents are listed chronologically by year, beginning with reports and committee prints, and followed by hearings.

Copies of committee hearings and reports are available from the committee and from the Government Printing Office. The date of publication and the number of copies you would like generally determine which office you should contact in requesting a publication.

The following are guidelines for ordering copies of committee publications:

—Single copies of publications printed after January 1987 can be obtained from the committee.

—Any publication printed before January 1987 should be ordered from the Government Printing Office.

—If you would like more than one copy of a publication, they should be ordered from the Government Printing Office.

*If the committee supply has been exhausted—as indicated by one asterisk—contact the Government Printing Office for a copy of the publication. If all supplies have been exhausted—contact your local Federal "Depository Library," which should have received a printed or microformed copy of the publication.

While a single copy of a publication is available, free of charge, from the committee, the Government Printing Office charges for publications.

ADDRESSES FOR REQUESTING PUBLICATIONS

Documents
Special Committee on Aging
SD-G31, U.S. Senate
Washington, D.C. 20510-6400
(202) 224-5364

Superintendent of Documents
Government Printing Office
Washington, D.C. 20402
(202) 783-3238

REPORTS

Developments in Aging, 1959 to 1963, Report No. 8, February 1963.*
Developments in Aging, 1963 and 1964, Report No. 124, March 1965.*
Developments in Aging, 1965, Report No. 1073, March 1966.*
Developments in Aging, 1966, Report No. 169, April 1967.*
Developments in Aging, 1967, Report No. 1098, April 1968.*
Developments in Aging, 1968, Report No. 91-119, April 1969.*
Developments in Aging, 1969, Report No. 91-875, May 1970.*
Developments in Aging, 1970, Report No. 92-46, March 1971.*
Developments in Aging: 1971 and January-March 1972, Report No. 92-784, May 1972.*
Developments in Aging: 1972 and January-March 1973, Report No. 93-147, May 1973.*
Developments in Aging: 1973 and January-March 1974, Report No. 93-846, May 1974.*
Developments in Aging: 1974 and January-April 1975, Report No. 94-250, June 1975.*
Developments in Aging: 1975 and January-May 1976—Part 1, Report No. 94-998, June 1976.*
Developments in Aging: 1975 and January-May 1976—Part 2, Report No. 94-998, June 1976.*
Developments in Aging: 1976—Part 1, Report No. 95-88, April 1977.*
Developments in Aging: 1976—Part 2, Report No. 95-88, April 1977.*
Developments in Aging: 1977—Part 1, Report No. 95-771, April 1978.*
Developments in Aging: 1977—Part 2, Report No. 95-771, April 1978.*
Developments in Aging: 1978—Part 1, Report No. 96-55, March 1979.*
Developments in Aging: 1978—Part 2, Report No. 96-55, March 1979.*
Developments in Aging: 1979—Part 1, Report No. 96-613, February 1980.*
Developments in Aging: 1979—Part 2, Report No. 96-613, February 1980.*
Developments in Aging: 1980—Part 1, Report No. 97-62, May 1981.*
Developments in Aging: 1980—Part 2, Report No. 97-62, May 1981.*

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Developments in Aging: 1981—Volume 1, Report No. 97-314, March 1982.*

Developments in Aging: 1981—Volume 2, Report No. 97-314, March 1982.*

Developments in Aging: 1982—Volume 1, Report No. 98-13, February 1983.*

Developments in Aging: 1982—Volume 2, Report No. 98-13, February 1983.*

Developments in Aging: 1983—Volume 1, Report No. 98-360, February 1984—$13.*

Developments in Aging: 1983—Volume 2, Report No. 98-360, February 1984—$8.*

Developments in Aging: 1984—Volume 1, Report No. 99-5, February 1985.—$9.*

Developments in Aging: 1984—Volume 2, Report No. 99-5, February 1985—$8.*

Developments in Aging: 1985—Volume 1, Report No. 99-242, February 1986.

Developments in Aging: 1985—Volume 2—Appendixes, Report No. 99-242, February 1986.*

Developments in Aging: 1985—Volume 3—America in Transition: An Aging Society.*

Developments in Aging: 1986—Volume 1, Report No. 100-9, February 1987.

Developments in Aging: 1986—Volume 2, Appendixes, Report No. 100-9, February 1987.*

Developments in Aging: 1986—Volume 3—America in Transition: An Aging Society, Report No. 100-9, February 1987.*

Developments in Aging: 1987—Volume 1, Report No. 100-291, February 1988.

Developments in Aging: 1987—Volume 2—Appendixes, Report No. 100-291, February 1988.*

Developments in Aging: 1987—Volume 3—The Long-Term Care Challenge, Report No. 100-291, February 1988.*

Developments in Aging: 1988—Volume 1—Report No. 101-4, February 1989.*

Developments in Aging: 1988—Volume 2—Appendixes, Report No. 101-4, February 1989.*

Developments in Aging: 1989—Volume 1—Report No. 101-249, February 1991.

Developments in Aging: 1989—Volume 2—Appendixes, Report No. 101-249, February 1991.

NOTE: When requesting or ordering publications in this listing, it is important that you first read the instructions on page 1.

COMMITTEE PRINTS

1961

Comparison of Health Insurance Proposals for Older Persons, 1961, committee print, April 1961.*

The 1961 White House Conference on Aging, basic policy statements and recommendations, committee print, May 1961.*

New Population Facts on Older Americans, 1960, committee print, May 1961.*

Basic Facts on the Health and Economic Status of Older Americans, staff report, committee print, June 1961.*

Health and Economic Conditions of the American Aged, committee print, June 1961.*

State Action To Implement Medical Programs for the Aged, committee print, June 1961.*

A Constant Purchasing Power Bond: A Proposal for Protecting Retirement Income, committee print, August 1961.*

Mental Illness Among Older Americans, committee print, September 1961.*

1962

Comparison of Health Insurance Proposals for Older Persons, 1961–62, committee print, May 1962.*

Background Facts on the Financing of the Health Care of the Aged, committee print, excerpts from the report of the Division of Program Research, Social Security Administration, Department of Health, Education, and Welfare, May 1962.*

Statistics on Older People: Some Current Facts About the Nation's Older People, June 1962.*

Performance of the States: 18 Months of Experience With the Medical Assistance for the Aged (Kerr-Mills) Program, committee print, June 1962.*

Housing for the Elderly, committee print, August 1962.*

Some Current Facts About the Nation's Older People, October 1962.*

1963

A Compilation of Materials Relevant to the Message of the President of the United States on Our Nation's Senior Citizens, committee print, June 1963.*

Medical Assistance for the Aged: The Kerr-Mills Program, 1960–63, committee print, October 1963.*

NOTE: When requesting or ordering publications in this listing, it is important that you first read the instructions on page 1.

1964

Blue Cross and Private Health Insurance Coverage of Older Americans, committee print, July 1964.*

Increasing Employment Opportunities for the Elderly—Recommendations and Comment, committee print, August 1964.*

Services for Senior Citizens—Recommendations and Comment, Report No. 1542, September 1964.*

Major Federal Legislative and Executive Actions Affecting Senior Citizens, 1963-64, committee print, October 1964.*

1965

Frauds and Deceptions Affecting the Elderly—Investigations, Findings, and Recommendations: 1964, committee print, January 1965.*

Extending Private Pension Coverage, committee print, June 1965.*

Health Insurance and Related Provisions of Public Law 89-97, The Social Security Amendments of 1965, committee print, October 1965.*

Major Federal Legislative and Executive Actions Affecting Senior Citizens, 1965, committee print, November 1965.*

1966

Services to the Elderly on Public Assistance, committee print, March 1966.*

The War on Poverty As It Affects Older Americans, Report No. 1287, June 1966.*

Needs for Services Revealed by Operation Medicare Alert, committee print, October 1966.*

Tax Consequences of Contributions to Needy Older Relatives, Report No. 1721, October 1966.*

Detection and Prevention of Chronic Disease Utilizing Multiphasic Health Screening Techniques, committee print, December 1966.*

1967

Reduction of Retirement Benefits Due to Social Security Increases, committee print, August 1967.*

1969

Economics of Aging: Toward a Full Share in Abundance, committee print, March 1969.* [1]

Homeownership Aspects of the Economics of Aging, working paper, factsheet, July 1969.* [1]

Health Aspects of the Economics of Aging, committee print, July 1969 (revised).* [1]

Social Security for the Aged: International Perspectives, committee print, August 1969.* [1]

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[1] Working paper incorporated as an appendix to the hearing.

NOTE: When requesting or ordering publications in this listing, it is important that you first read the instructions on page 1.

Employment Aspects of the Economics of Aging, committee print, December 1969.* [1]

1970

Pension Aspects of the Economics of Aging: Present and Future Roles of Private Pensions, committee print, January 1970.* [1]

The Stake of Today's Workers in Retirement Security, committee print, April 1970.* [1]

Legal Problems Affecting Older Americans, committee print, August 1970.* [1]

Income Tax Overpayments by the Elderly, Report No. 91-1464, December 1970.*

Older Americans and Transportation: A Crisis in Mobility, Report No. 91-1520, December 1970.*

Economics of Aging: Toward a Full Share in Abundance, Report No. 91-1548, December 1970.*

1971

Medicare, Medicaid Cutbacks in California, working paper, factsheet, May 10, 1971.*

The Nation's Stake in the Employment of Middle-Aged and Older Persons, committee print, July 1971.*

The Administration on Aging—Or a Successor?, committee print, October 1971.*

Alternatives to Nursing Home Care: A Proposal, committee print, October 1971.*

Mental Health Care and the Elderly: Shortcomings in Public Policy, Report No. 92-433, November 1971.*

The Multiple Hazards of Age and Race: The Situation of Aged Blacks in the United States, Report No. 92-450, November 1971.*

Advisory Council on the Elderly American Indian, committee print, November 1971.*

Elderly Cubans in Exile, committee print, November 1971.*

A Pre-White House Conference on Aging: Summary of Developments and Data, Report No. 92-505, November 1971.*

Research and Training in Gerontology, committee print, November 1971.*

Making Services for the Elderly Work: Some Lessons From the British Experience, committee print, November 1971.*

1971 White House Conference on Aging, a report to the delegates from the conference sections and special concerns sessions, Document No. 92-53, December 1971.*

1972

Home Health Services in the United States, committee print, April 1972.*

Proposals To Eliminate Legal Barriers Affecting Elderly Mexican-Americans, committee print, May 1972.*

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*NOTE: When requesting or ordering publications in this listing, it is important that you first read the instructions on page 1.

Cancelled Careers: The Impact of Reduction-in-Force Policies on Middle-Aged Federal Employees, committee print, May 1972.*

Action on Aging Legislation in 92d Congress, committee print, October 1972.*

Legislative History of the Older Americans Comprehensive Services Amendments of 1972, joint committee print, prepared by the Subcommittee on Aging of the Committee on Labor and Public Welfare and the Special Committee on Aging, December 1972.*

1973

The Rise and Threatened Fall of Service Programs for the Elderly, committee print, March 1973.*

Housing for the Elderly: A Status Report, committee print, April 1973.*

Older Americans Comprehensive Services Amendments of 1973, committee print, June 1973.*

Home Health Services in the United States: A Working Paper on Current Status, committee print, July 1973.*

Economics of Aging: Toward a Full Share in Abundance, index to hearings and report, committee print, July 1973.*

Research on Aging Act, 1973, Report No. 93-299, committee print, July 1973.*

Post-White House Conference on Aging Reports, 1973, joint committee print, prepared by the Subcommittee on Aging of the Committee on Labor and Public Welfare and the Special Committee on Aging, September 1973.*

Improving the Age Discrimination Law, committee print, September 1973.*

1974

The Proposed Fiscal 1975 Budget: What It Means for Older Americans, committee print, February 1974.*

Protecting Older Americans Against Overpayment of Income Taxes, committee print, February 1974.*

Developments and Trends in State Programs and Services for the Elderly, committee print, November 1974.*

Nursing Home Care in the United States: Failure in Public Policy:*

- Introductory Report, Report No. 93-1420, November 1974.
- Supporting Paper No. 1, "The Litany of Nursing Home Abuses and an Examination of the Roots of Controversy," committee print, December 1974.
- Supporting Paper No. 2, "Drugs in Nursing Homes: Misuse, High Costs, and Kickbacks," committee print, January 1975.
- Supporting Paper No. 3, "Doctors in Nursing Homes: The Shunned Responsibility," committee print, February 1975.
- Supporting Paper No. 4, "Nurses in Nursing Homes: The Heavy Burden (the Reliance on Untrained and Unlicensed Personnel)," committee print, April 1975.
- Supporting Paper No. 5, "The Continuing Chronicle of Nursing Home Fires," committee print, August 1975.

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Supporting Paper No. 6, "What Can Be Done in Nursing Homes: Positive Aspects in Long-Term Care," committee print, September 1975.

Supporting Paper No. 7, "The Role of Nursing Homes in Caring for Discharged Mental Patients (and the Birth of a For-Profit Boarding Home Industry)," committee print, March 1976.

Private Health Insurance Supplementary to Medicare, committee print, December 1974.*

1975

Protecting Older Americans Against Overpayment of Income Taxes, committee print, January 1975.*

Senior Opportunities and Services (Directory of Programs), committee print, February 1975.*

Action on Aging Legislation in 93d Congress, committee print, February 1975.*

The Proposed Fiscal 1976 Budget: What It Means for Older Americans, committee print, February 1975.*

Future Directions in Social Security, Unresolved Issues: An Interim Staff Report, committee print, March 1975.*

Women and Social Security: Adapting to a New Era, working paper, committee print, October 1975.*

Congregate Housing for Older Adults, Report No. 94-478, November 1975.*

1976

Protecting Older Americans Against Overpayment of Income Taxes, committee print, January 1976.*

The Proposed Fiscal 1977 Budget: What It Means for Older Americans, committee print, February 1976.*

Fraud and Abuse Among Clinical Laboratories, Report No. 94-944, June 1976.*

Recession's Continuing Victim: The Older Worker, committee print, July 1976.*

Fraud and Abuse Among Practitioners Participating in the Medicaid Program, committee print, August 1976.*

Adult Day Facilities for Treatment, Health Care, and Related Services, committee print, September 1976.*

Termination of Social Security Coverage: The Impact on State and Local Government Employees, committee print, September 1976.*

Witness Index and Research Reference, committee print, November 1976.*

Action on Aging Legislation in 94th Congress, committee print, November 1976.*

Protecting Older Americans Against Overpayment of Income Taxes, committee print, December 1976.*

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1977

The Proposed Fiscal 1978 Budget: What It Means for Older Americans, committee print, March 1977.*

Kickbacks Among Medicaid Providers, Report No. 95-320, June 1977.*

Protective Services for the Elderly, committee print, July 1977.*

The Next Steps in Combating Age Discrimination in Employment: With Special Reference to Mandatory Retirement Policy, committee print, August 1977.*

Protecting Older Americans Against Overpayment of Income Taxes, committee print, December 1977.*

1978

The Proposed Fiscal 1979 Budget: What It Means for Older Americans, committee print, February 1978.*

Paperwork and the Older Americans Act: Problems of Implementing Accountability, committee print, June 1978.*

Single Room Occupancy: A Need for National Concern, committee print, June 1978.*

Protecting Older Americans Against Overpayment of Income Taxes, committee print, December 1978.*

Action on Aging Legislation in the 95th Congress, committee print, December 1978.*

1979

The Proposed Fiscal 1980 Budget: What It Means for Older Americans, committee print, February 1979.*

Energy Assistance Programs and Pricing Policies in the 50 States To Benefit Elderly, Disabled, or Low-Income Households, committee print, October 1979.*

Witness Index and Research Reference, committee print, November 1979.*

1980

Protecting Older Americans Against Overpayment of Income Taxes, committee print, January 1980.*

The Proposed Fiscal 1981 Budget: What It Means for Older Americans, committee print, February 1980.*

Emerging Options for Work and Retirement Policy (An Analysis of Major Income and Employment Issues With an Agenda for Research Priorities), committee print, June 1980.*

Summary of Recommendations and Surveys on Social Security and Pension Policies, committee print, October 1980.*

Innovative Developments in Aging: State Level, committee print, October 1980.*

State Offices on Aging: History and Statutory Authority, committee print, December 1980.*

Protecting Older Americans Against Overpayment of Income Taxes, committee print, December 1980.*

NOTE: When requesting or ordering publications in this listing, it is important that you first read the instructions on page 1.

State and Local Government Terminations of Social Security Coverage, committee print, December 1980.*

1981

The Proposed Fiscal Year 1982 Budget: What It Means for Older Americans, committee print, April 1981.*

Action on Aging Legislation in the 96th Congress, committee print, April 1981.*

Energy and the Aged, committee print, August 1981.*

1981 Federal Income Tax Legislation: How It Affects Older Americans and Those Planning for Retirement, committee print, August 1981.*

Omnibus Budget Reconciliation Act of 1981, Public Law 97-35, committee print, September 1981.*

Toward a National Older Worker Policy, committee print, September 1981.*

Crime and the Elderly—What You Can Do, committee print, September 1981.*

Social Security in Europe: The Impact of an Aging Population, committee print, December 1981.*

Background Materials Relating to Office of Inspector General, Department of Health and Human Services Efforts To Combat Fraud, Waste, and Abuse, committee print, December 1981.*

Protecting Older Americans Against Overpayment of Income Taxes, committee print, December 1981.*

A Guide to Individual Retirement Accounts (IRA's), committee print, December 1981, stock No. 052-070-05666-5—$2.*

1982

Social Security Disability: Past, Present, and Future, committee print, March 1982.*

The Proposed Fiscal Year 1983 Budget: What It Means for Older Americans, committee print, March 1982.*

Linkages Between Private Pensions and Social Security Reform, committee print, April 1982.*

Health Care Expenditures for the Elderly: How Much Protection Does Medicare Provide?, committee print, April 1982.*

Turning Home Equity Into Income for Older Homeowners, committee print, July 1982, stock No. 052-070-05753-0—$1.25.*

Aging and the Work Force: Human Resource Strategies, committee print, August 1982.*

Fraud, Waste, and Abuse in the Medicare Pacemaker Industry, committee print, September 1982, stock No. 052-070-05777-7—$6.*

Congressional Action on the Fiscal Year 1983 Budget: What It Means for Older Americans, committee print, November 1982.*

Equal Employment Opportunity Commission Enforcement of the Age Discrimination in Employment Act: 1979 to 1982, committee print, November 1982.*

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Protecting Older Americans Against Overpayment of Income Taxes, committee print, December 1982.*

1983

Consumer Frauds and Elderly Persons: A Growing Problem, committee print, February 1983, stock No. 052-070-05823-4—$4.50.*

Action on Aging Legislation in the 97th Congress, committee print, March 1983.*

Prospects for Medicare's Hospital Insurance Trust Fund, committee print, March 1983.*

The Proposed Fiscal Year 1984 Budget: What It Means for Older Americans, committee print, March 1983.*

You and Your Medicines: Guidelines for Older Americans, committee print, June 1983.*

Heat Stress and Older Americans: Problems and Solutions, committee print, July 1983.*

Current Developments in Prospective Reimbursement Systems for Financing Hospital Care, committee print, October 1983.*

Protecting Older Americans Against Overpayment of Income Taxes, committee print, December 1983.*

1984

Medicare: Paying the Physician—History, Issues, and Options, committee print, March 1984.

Older Americans and the Federal Budget: Past, Present, and Future, committee print, April 1984.*

Medicare and the Health Cost of Older Americans: The Extent and Effects of Cost Sharing, committee print, April 1984, Stock No. 052-050-05916-8, $2.

The Supplemental Security Income Program: A 10-Year Overview, committee print, May 1984, Stock No. 052-050-05928-1, $6.50.*

Long-Term Care in Western Europe and Canada: Implications for the United States, committee print, July 1984.

Turning Home Equity Into Income for Older Americans, committee print, July 1984, stock No. 052-070-05753-3, $1.25.

The Employee Retirement Income Security Act of 1974: The First Decade, committee print, August 1984, stock No. 052-070-05950-8, $5,50.

The Costs of Employing Older Workers, committee print, September 1984.*

Rural and Small-City Elderly, committee print, September 1984.*

Section 202 Housing for the Elderly and Handicapped: A National Survey, committee print, December 1984.*

Protecting Older Americans Against Overpayment of Income Taxes, committee print, December 1984, stock No. 052-070-05984-2, $1.25.*

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1985

Health and Extended Worklife, committee print, February 1985.

Personnel Practices for an Aging Workforce: Private-Sector Examples, committee print, February 1985.*

10th Anniversary of the Employee Retirement Income Security Act of 1974, committee print, April 1985.

Publications list, committee print, April 1985.*

Compilation of the Older Americans Act of 1965 and Related Provisions of Law, committee print, Serial No. 99-A, June 1985.

America In Transition: An Aging Society, 1984-85 Edition, committee print, Serial No. 99-B, June 1985.*

Fifty Years of Social Security: Past Achievements and Future Challenges, committee print, Serial No. 99-C, August 1985.

How Older Americans Live: An Analysis of Census Data, committee print, Serial No. 99-D, October 1985.*

Congressional Briefing on the 50th Anniversary of Social Security, committee print, Serial No. 99-E, August 1985.

1986

Protecting Older Americans Against Overpayment of Income Taxes, committee print, Serial No. 99-F, January 1986.*

The Cost of Mandating Pension Accruals for Older Workers, committee print, Serial No. 99-G, February 1986.

The Impact of Gramm-Rudman-Hollings on Programs Serving Older Americans: Fiscal Year 1986, committee print, Serial No. 99-H, February 1986.*

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1987

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1991

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An Ounce of Prevention: Health Care Guide for Older Americans January 1991, Serial No. 102-B.

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Retirement Income of the Aging:*
  Part 1. Washington, D.C., July 12 and 13, 1961.
  Part 2. St. Petersburg, Fla., November 6, 1961.
  Part 3. Port Charlotte, Fla., November 7, 1961.
  Part 4. Sarasota, Fla., November 8, 1961.
  Part 5. Springfield, Mass., November 29, 1961.
  Part 6. St. Joseph, Mo., December 11, 1961.
  Part 7. Hannibal, Mo., December 13, 1961.
  Part 8. Cape Girardeau, Mo., December 15, 1961.
  Part 9. Daytona Beach, Fla., February 14, 1962.
  Part 10. Fort Lauderdale, Fla., February 15, 1962.
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  Part 3. Los Angeles, Calif., October 24, 1961.
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  Part 2. Newark, N.J., October 26, 1962.
  Part 3. Camden, N.J., October 29, 1962.
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  Part 6. San Francisco, Calif., December 7, 1962.
Frauds and Quackery Affecting the Older Citizen:*
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  Part 1. Washington, D.C., December 11, 1963.
  Part 2. Los Angeles, Calif., January 9, 1964.
  Part 3. San Francisco, Calif., January 11, 1964.
Long-Term Institutional Care for the Aged, Washington, D.C., December 17 and 18, 1963.*
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  Part 4. Saginaw, Mich., March 2, 1964.
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  Part 1. Washington, D.C., April 27, 1964.
  Part 2. Washington, D.C., April 28, 1964.
  Part 3. Washington, D.C., April 29, 1964.
  Part 4A. Appendix.
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Deceptive or Misleading Methods in Health Insurance Sales, Washington, D.C., May 4, 1964.*
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  Part 1. Indianapolis, Ind., February 11, 1965.
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The War on Poverty As It Affects Older Americans:*
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Needs for Services Revealed by Operation Medicare Alert, Washington, D.C., June 2, 1966.*
Tax Consequences of Contributions to Needy Older Relatives, Washington, D.C., June 15, 1966.*
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  Part 1. Washington, D.C., January 17 and 18, 1967.
  Part 2. Tampa, Fla., February 3, 1967.
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  Part 2. Ann Arbor, Mich., July 26, 1967.
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  Part 1. Washington, D.C., June 22 and 23, 1967.
  Part 2. New York, N.Y., October 19, 1967.
  Part 3. Los Angeles, Calif., October 16, 1968.
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  Part 1. Washington, D.C., July 23, 1968.
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  Part 3. Ogden, Utah, October 24, 1968.
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  Part 5. Atlanta, Ga., December 11, 1968.
  Part 6. Boston, Mass., July 11, 1969.
  Part 7. Washington, D.C., October 14 and 15, 1969.
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Availability and Usefulness of Federal Programs and Services to Elderly Mexican-Americans: *
  Part 1. Los Angeles, Calif., December 17, 1968.
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  Part 4. Washington, D.C., January 14 and 15, 1969.
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  Part 1. Washington, D.C., survey hearing, April 29 and 30, 1969.
  Part 2. Ann Arbor, Mich., consumer aspects, June 9, 1969.
  Part 3. Washington, D.C., health aspects, July 17 and 18, 1969.
  Part 4. Washington, D.C., homeownership aspects, July 31 and August 1, 1969.
  Part 5. Paramus, N.J., central suburban area, August 14, 1969.
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  Part 7. Washington, D.C., international perspectives, August 25, 1969.
  Part 8. Washington, D.C., national organizations, October 29, 1969.
  Part 9. Washington, D.C., employment aspects, December 18 and 19, 1969.
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  Part 1. Ocean Grove, N.J., April, 18, 1970.
  Part 2. Washington, D.C., June 8 and 9, 1970.
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  Part 1. St. Louis, Mo., August 11, 1970.
  Part 2. Boston, Mass., April 30, 1971.
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    Part 2. Roanoke, Ala., August 10, 1971.
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    Part 4. Pocatello, Idaho, August 27, 1971.
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    Part 13. Washington, D.C., October 7, 1975.
    Part 14. Washington, D.C., October 8, 1975.
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    Part 1. Washington, D.C., October 18, 1971.
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  Part 2. Washington, D.C., September 13, 1979.
  Part 3. Pennsauken, N.J., May 23, 1980.
  Part 4. Washington, D.C., July 25, 1980.
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  Part 2. Washington, D.C., May 22, 1980.
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Part 1. Washington, D.C., November 21, 1980.
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The Future of Medicare, Washington, D.C., April 13, 1983.*

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Drug Use and Misuse: A Growing Concern for Older Americans (joint hearing with the Subcommittee on Health and Long-Term Care of the House Select Committee on Aging), Washington, D.C., June 28, 1983.*

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Social Security: How Well Is It Serving the Public? Washington, D.C., November 29, 1983.
The Crisis in Medicare: Proposals for Reform, Sioux City, Iowa, December 13, 1983.*
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  Part 2. Dallas, Tex., February 17, 1984.
  Part 3. Hot Springs, Ark., March 24, 1984.
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Unnecessary Surgery: Double Jeopardy for Older Americans, Washington, DC, March 14, 1985, Serial No. 99-1.
Rural Health Care in Oklahoma, Oklahoma City, OK, April 9, 1985, Serial No. 99-2.
Prospects for Better Health for Older Women, Toledo, OH, April 15, 1985, Serial No. 99-3.*
Pacemakers Revisited: A Saga of Benign Neglect, Washington, DC, May 10, 1985, Serial No. 99-4, Stock No. 552-070-00035-6, $25.

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The Pension Gamble: Who Wins? Who Loses? Washington, DC, June 14, 1985, Serial No. 99-5.

Americans At Risk: The Case of the Medically Uninsured, Washington, DC, June 27, 1985, Serial No. 99-6.

The Graying of Nations II, New York, NY, July 12, 1985, Serial No. 99-7, stock No. 052-070-06113-8, $4.75.*

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Challenges for Women: Taking Charge, Taking Care, Cincinnati, OH, November 18, 1985, Serial No. 99-12, stock No. 552-070-00264-2, $2.50.*

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The Older Americans Act and Its Application to Native Americans, Oklahoma City, OK, June 28, 1986, Serial No. 99-22, stock No. 552-070-00836-5, $6.

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Providing a Comprehensive and Compassionate Long-Term Health Care Program for America's Senior Citizens, New Haven, CT, July 7, 1986, Serial No. 99-23, stock No. 552-070-00849-7, $3.50.
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  Part 1. Fort Smith, AR, August 27, 1986.
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Proposed Fiscal Year 1988 Budget: What it Means to Older Americans, Washington, DC, March 13, 1987, Serial No. 100-3.
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- Part 2—Rural Health Care Personnel, Washington, DC, July 11, 1988, Serial No. 100-23.

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Medicare Coverage of Catastrophic Health Care Cost: What Do Seniors Need, What Do Seniors Want? Las Vegas, NV October 10, 1989, Serial No. 101-11.

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